Public Health
Annual Report 2006-2007

Children and young people: changing the health environment in Suffolk

in partnership with

Suffolk
Primary Care Trust

Suffolk County Council
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Foreword

1.1 Is the health of children and young people getting worse or better?
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Scenarios to consider
Welcome to the report of the Director of Public Health for Suffolk County Council and Suffolk Primary Care Trust in 2007 – the first joint report on public health from these organisations.

In October 2006, the post of director of public health was moved from the previous Primary Care Trusts (Suffolk West, Central Suffolk, Suffolk Coastal and Ipswich) to a joint post in the new Suffolk PCT and Suffolk County Council. This post promotes joint working to tackle the real causes of poor health in the community. I hope that intention is clearly reflected in this year’s report which focuses on the health of children and young people in Suffolk.

In the report, we use a number of case studies and illustrations to examine topics which are vital for improving and sustaining good health for this important age group. You are invited to comment on the report and on how we as a community can change the health environment for children, young people and families in Suffolk. Any comments can be sent directly to me
- peter.bradley@suffolkpct.nhs.uk

Yours sincerely

Dr. Peter Bradley, Director of Public Health
1.1 Is the health of children and young people getting worse or better?

Social, educational, environmental and medical advances have continually benefited child health in the last few decades. Children and young people are definitely getting healthier, but despite advances, there are still concerns about their health in the UK – mostly related to their lifestyle choices and relative poverty. According to a recent United Nations study (UNICEF 2007), children growing up in the UK have unsafe sex, abuse drugs and drink alcohol more often than those in any other wealthy country in the world. They also have worse relationships with parents and suffer greater economic deprivation, because of persistent social and health inequalities and the impact of lifestyle choices.

1.2 What are the health problems for children and young people in Suffolk?

Suffolk has a population of just under 700,000, of which nearly 166,000 (24%) are people aged below 19. Suffolk is a changing community. Our population is expected to rise by 14% in the next 20 years, but there will only be a 1% rise in the number of under 19s. There are increasing numbers of children from ethnic minority backgrounds. Some 70 different languages are now spoken in Suffolk schools.

Children in Suffolk are generally healthy, with 84% of children in school years 8 to 10 reporting themselves to be healthy or fairly healthy. In addition, educational achievement (a strong predictor of future health) is better than for much of England. However, the health of Suffolk children does not compare favourably with that of other European countries and there is marked variation in health outcomes across the county. In 2006, a previous public health report showed a clear relationship between relative poverty and poorer educational achievement in Suffolk. Average life expectancy currently varies by approximately 10 years by electoral ward within Suffolk.

More than 19,000 children under the age of 16 in Suffolk live in households experiencing income deprivation (Indices of Multiple Deprivation 2004), about 700 children are ‘Looked After Children’ for whom the county council has a statutory parenting role and around 400 children are on the child protection register. There are also 7,500 children with disabilities, and approximately 18,000 children with some kind of Special Educational Need.
Regarding lifestyle, 10% of five year olds and over 18% of 11 year olds are obese, and 9% of 11-15 year olds are estimated to smoke. The accident rate for young people is higher than the national average and educational attainment post-16 is lower. Alcohol abuse, teenage pregnancy and homelessness are particular concerns, especially in Ipswich and Lowestoft.

Failure to reverse these lifestyle trends and tackle poverty in Suffolk will lead to a marked increase in preventable conditions eg diabetes, cardiovascular disease, cancer and poorer mental health. This is particularly the case in economically disadvantaged communities and is both expensive and unnecessary.

1.3 How can children and young people in Suffolk become or remain healthy?

We know that simply offering people a ‘healthy choice’ can work but often doesn’t. This is particularly the case for children and young people, who are heavily influenced by peers and family.

If we are serious about improving the health of children and young people we must now develop some radical, local approaches which not only influence our social, educational, health and wellbeing services, but also offer considerable improvements to our physical and educational environment so that healthy choices become the cultural norm, in a way that has been achieved in other Western European countries. Every decision, whether it is about environmental planning, economic development, housing, transport, education or health service development, will impact on the health of our community.

The future of Suffolk is clearly dependent upon the degree to which we embrace change and work together as a community. The case studies and scenarios that follow illustrate how we think Suffolk can radically change to protect our children and young people’s health in the next 20 years. We would like you to reflect on them as you read the rest of the report, and use them to stimulate your imagination about how the health of the population of Suffolk could be changed.

Scenario 1 The health of the population and environment remain static or worsens in some areas, but other services improve because of increased investment.

Scenario 2 There is some health improvement but with no change to the environment. The degree of improvement varies in different parts of Suffolk and may worsen in some.

Scenario 3 There are marked improvements in health and the environment in more deprived parts of Suffolk. Health inequalities between population groups reduce.

Scenario 4 There are marked improvements in health and the environment in the whole of Suffolk. Inequalities between different population groups may however widen.
Case study 1:
Hailey - age two and a half; pre-school child.

 Scenario 1 Suffolk without enhanced wellbeing services

- The health visitor occasionally comes to see Hailey.
- Hailey plays with other children in the park/playground when her mother can take her.
- The road by Hailey's house is busy and the footpath is narrow and uneven. Hailey's mum finds it difficult to take her out for a walk in her pushchair.

 Scenario 2 Suffolk with enhanced wellbeing services

- Hailey's mother regularly takes her to see her health visitor.

 Scenario 3 Suffolk with enhanced wellbeing services and an improved environment specifically targeting deprived groups in the community

- Nothing further changes for Hailey.

 Scenario 4 Suffolk with enhanced wellbeing services and an improved environment targeting all members of the community

- The footpath near Hailey's home has been widened and paved. The speed limit on the busy road is now reduced. Hailey's mother now regularly takes her out for walks.
- Hailey's mother is part of a “mother-and-toddler walking club” set up by a local community group. They now regularly take walks as a group.
Case study 2:  
Billy - age eleven; school-going child.

**Scenario 1** Suffolk without enhanced wellbeing services
- Billy lives less than a mile away from school. His parents drop him off in their car every morning.
- Billy has some PE sessions at school but is not always allowed to play outside during break times. His class gets one turn a week on the school’s climbing frame, in the summer if it is not raining on ‘their’ day. He loves playing games on his PlayStation 2 after school.
- Billy has asthma and often has to see his GP.
- Today Billy’s mum made him a packed lunch - a sandwich, crisps, a chocolate bar and some juice.
- Billy and his parents went on a day out to Thetford Forest when he was on half term.

**Scenario 2** Suffolk with enhanced wellbeing services
- Billy and his parents have learnt to manage his asthma better. They now make fewer visits to their GP.
- Billy’s school has initiated a “healthy eating” programme for parents and pupils. Billy’s mum now adds fruit to his packed lunch instead of a chocolate bar.

**Scenario 3** Suffolk with enhanced wellbeing services and an improved environment specifically targeting deprived groups in the community
- Nothing further changes for Billy.

**Scenario 4** Suffolk with enhanced wellbeing services and an improved environment targeting all members of the community
- Billy has had safe-cycling lessons and now cycles to school each morning.
- He also has more PE sessions and is encouraged to engage in active play outside during break times.
- Billy gets sports coaching after school and on weekends. He is now a member of an under-12’s football team.
Case study 3:
Anne - age fifteen; an adolescent.

Scenario 1 Suffolk without enhanced wellbeing services
- Anne thinks she may be pregnant and is unable to concentrate on her studies while at school. She is not sure who to speak to about her concerns.
- She spends a lot of time with her friends after school and at times they smoke.

Scenario 2 Suffolk with enhanced wellbeing services
- Anne can go to the school nurse or to her GP surgery for some advice.
- She can also access confidential advice and information online.

Scenario 3 Suffolk with enhanced wellbeing services and an improved environment specifically targeting deprived groups in the community
- Nothing further changes for Anne.

Scenario 4 Suffolk with enhanced wellbeing services and an improved environment targeting all members of the community
- Anne’s school has a one-stop-shop that offers advice to teenagers on drugs, alcohol, bullying, sexual health and relationships (DH 2004).
Case study 4:
Paul – age thirty-eight; a working parent.

**Scenario 1** Suffolk without enhanced wellbeing services
- Paul drops his children off at school (less than one mile from home) then drives to work (three miles from home).
- He spends most of the day at his desk working. He often has lunch at the work canteen and gets snacks from the vending machine.
- Paul has no major health problems and rarely sees his GP. He knows that he has put on a lot of weight over the years but is too busy to exercise.

**Scenario 2** Suffolk with enhanced wellbeing services
- Paul has an annual health check at his GP surgery. His weight, height and blood pressure is measured and he gets advice on losing weight.

**Scenario 3** Suffolk with enhanced wellbeing services and an improved environment specifically targeting deprived groups in the community
- Nothing further changes for Paul.

**Scenario 4** Suffolk with enhanced wellbeing services and an improved environment targeting all members of the community
- Paul’s town initiated a new traffic transport policy involving its citizens. The policy gives first priority in all political and planning decisions to pedestrians, second to cyclists, third to public transportation and last to the car (WHO 1999).
- Paul’s local council has now created several cycle paths and produced a cycle map.
- Paul now cycles to work and has lost some weight. His children also walk or cycle to school (WHO 2002, WHO 2003)
- Paul has also volunteered to coach the local under-10’s football team.
Case study 5: Edna - age eighty; an older person and grandmother.

**Scenario 1** Suffolk without enhanced wellbeing services
- Edna has diabetes and sees her GP for this several times a year.
- She fears going out to the local shop on her bike or for walks because the traffic outside her home is too fast.
- Edna would also like to go swimming and visit her granddaughter who lives nearby, but finds it difficult to get there especially during winter.

**Scenario 2** Suffolk with enhanced wellbeing services
- Edna is getting help with managing her diabetes from her nurse specialist advisor.
- Edna is also part of an Expert Patient Programme on diabetes and now sees her GP less frequently, often only for check-ups.

**Scenario 3** Suffolk with enhanced wellbeing services and an improved environment specifically targeting deprived groups in the community
- Nothing further changes for Edna.

**Scenario 4** Suffolk with enhanced wellbeing services and an improved environment targeting all members of the community
- The speed limit on the road outside Edna’s home is now reduced. She now finds it safe enough to take a walk every day.
- Edna went on a course for older cyclists and is now more confident about cycling (WHO 2002)
- The sports centre now has a free bus service. Edna gets the bus to go swimming three times a week all year round and offers regular childcare for her granddaughter (WHO 2002)
Case study 6:
Charlie – age nine; school-going child but living in poverty.

Scenario 1 Suffolk without enhanced wellbeing services
- Charlie doesn’t play outside at school because he is often teased about being fat. He is actually obese but has not had his weight measured since he was five.
- Today Charlie took a packed lunch. He had crisps, chicken nuggets and a coke.
- Charlie lives in a block of terraced houses with his mum and brother. They rarely go out to play, because the playground next to their home was recently vandalised and it is no longer safe for them to play on.
- Charlie’s mum hasn’t got a car and cannot afford to take them out during school holidays.

Scenario 2 Suffolk with enhanced wellbeing services
- Charlie now has his weight checked at school and by his GP.
- Charlie no longer takes a packed lunch. He has free school lunch and now eats some fruit and vegetables at school every day.

Scenario 3 Suffolk with enhanced wellbeing services and an improved environment specifically targeting deprived groups in the community
- The streets next to Charlie’s home are now clean, well lit and safe. The playground nearby was also refurbished. Charlie and his brother can play outside.

Scenario 4 Suffolk with enhanced wellbeing services and an improved environment targeting all members of the community
- Charlie’s school has started a “walking bus” and he walks to school each morning.
- He is also part of an after school activity club. He has lost some weight and the other kids at school do not tease him about being fat.
- There is a new recreational green space close to Charlie’s home. It is free for everyone to use. Charlie’s mother takes the boys out to walk/cycle during school holidays (WHO 2003).
Case study 7: Lisa – age twenty-four; single mother living in a deprived area.

**Scenario 1** Suffolk without enhanced wellbeing services
- Lisa smokes half a pack of cigarettes every day.
- She stays at home most of the time and cannot afford to take her three-year old child to a nursery or a child-minder.
- Lisa tries to buy healthy food for her child but finds some of the food labels in the supermarket confusing. Fruit and vegetables are also too expensive.

**Scenario 2** Suffolk with enhanced wellbeing services
- Lisa gets regular visits and advice from the health visitor.
- She also has access to a stop-smoking clinic.
- Lisa takes her child to a toddlers group at the Sure Start centre and while her child is there, she attends a cookery class and learns how to prepare healthy meals.

**Scenario 3** Suffolk with enhanced wellbeing services and an improved environment specifically targeting deprived groups in the community
- Lisa has an urban allotment close to her home where she grows some vegetables for her own use (WHO 2003).
- Local farmers grow a variety of fruit/vegetables all year round. Through the food co-op, Lisa can now afford to buy some fruit and vegetables.

**Scenario 4** Suffolk with enhanced wellbeing services and an improved environment targeting all members of the community
- Lisa has access to fruit and vegetables each day.
- The food labels at the supermarket are now a lot easier to understand.
Case study 8:  
Jack- age fifteen; homeless young person.

**Scenario 1** Suffolk without enhanced wellbeing services

- Jack ran away from home to escape from his abusive step-father.
- He has been living in a squat for several months but this was hastily closed by the police and he now has nowhere to go.
- He has no money to buy regular meals and often sleeps hungry.
- Over the last few months, he has developed a persistent itchy rash on his wrists and hands. He does not have a GP and thinks he probably should go to hospital when it gets worse.
- Jack feels lonely and needs to find some “speed” to make him feel less hungry and a lot happier.

**Scenario 2** Suffolk with enhanced wellbeing services

- Through the Health Outreach Project (HOP) nurse, Jack has received treatment for scabies, a change of clothing and access to food and washing facilities. The itchy rash has now disappeared.
- The HOP nurse and outreach worker have put Jack in contact with the NORCAS youth service (NORCAS 2007) and Social Services.
- Jack gets some respite by staying with a local family on some nights thanks to the YMCA’s “Nightstop” scheme (YMCA 2006).

**Scenario 3** Suffolk with enhanced wellbeing services and an improved environment specifically targeting deprived groups in the community

- Nothing further changes for Jack.

**Scenario 4** Suffolk with enhanced wellbeing services and an improved environment targeting all members of the community

- Jack has kicked his habit and is now drug free.
- Jack is now being housed in clean, safe and friendly accommodation.
- He goes to college and is also on a work placement. He hopes to become an engineer in the future.
- Jack gets regular visits from a HOP health visitor.
- He now regularly uses his local youth centre and takes part in several organised outdoor activities (Suffolk County Council 2007).
- He is able to access useful information on the internet and is also part of an online support group for young people like himself (Suffolk County Council 2007).
Case study 9:  
Elizabeth – age sixty-six; cares for her daughter Alison, age twenty-seven who has Down’s Syndrome.

**Scenario 1**  
**Suffolk without enhanced wellbeing services**
- Elizabeth lives with her daughter Alison in a rural two-bedroom cottage.
- Her husband died 5 years ago and she is now Alison's sole carer.
- Elizabeth has to rely on benefits because Alison needs full time care.
- Alison occasionally attends a day centre. She used to go there more regularly in the past.
- Since her husband died, Elizabeth has found it difficult to take Alison to the day centre because her car is old and often breaks down.

**Scenario 2**  
**Suffolk with enhanced wellbeing services**
- Elizabeth occasionally gets support to enable her to attend training courses and events organised by the Down’s Syndrome Association.
- Alison has a thyroid problem associated with her condition. She has a structured healthcare plan and needs to visit the hospital for regular check-ups.
- Elizabeth finds it difficult to take Alison to her hospital appointments because they live quite a distance from the hospital and she often has car trouble.

**Scenario 3**  
**Suffolk with enhanced wellbeing services and an improved environment specifically targeting deprived groups in the community**
- Alison gets frequent visits at home from her community matron and does not have to go to the hospital for her check-ups.
- The community matron helped Elizabeth and Alison access all the benefits they were entitled to.
- Elizabeth is now able to get a newer car. As a result, Alison can attend the day centre three times a week and is learning valuable skills.

**Scenario 4**  
**Suffolk with enhanced wellbeing services and an improved environment targeting all members of the community**
- The day centre was recently renovated and now has a variety of sports facilities for people with disabilities and learning difficulties. Alison loves sport and is able to access the facilities on a regular basis.
- Elizabeth does some part time work when Alison is at the day centre. They are now not entirely dependent on benefits.
- Elizabeth also receives some respite services when possible and is able to take a break from caring for Alison.
References

- Page 65 – Case study – the MAC’s programme. London, DH

NORCAS is an open access drug and alcohol charity operating from teams based throughout Norfolk and Suffolk. Their mission statement is “to reduce the harm to individuals, and thereby to society at large, from the misuse of drugs and alcohol”. NORCAS works with people experiencing problems with alcohol, drugs, tranquillisers or solvents, including families and carers. Their website is: http://www.norcas.org.uk/ accessed 2007.


- Page 28: Case study - Salzburg, Austria: new traffic policy.

- Page 12: The Dutch Cyclists Union runs courses for older cyclists to encourage safe cycling, improve confidence and continuity of the cycling habit. Similar scheme in Belgium.
- Page 15: evidence on reducing speed limits increases cycle use and reduces cycle accidents; improving conditions for pedestrians e.g. Graz, Austria; Munich, Germany.

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- YMCA scheme offering emergency accommodation to vulnerable young people.
- Scheme provides a network of homes where young people aged 16-17 years with nowhere to go for the night can get a bed, evening meal, breakfast and washing facilities.
2
Progress on the recommendations in the 2006 reports of the Suffolk Directors of Public Health

2.1 Health inequalities
2.2 Educational achievement and deprivation
2.3 Mental health
2.4 General public health issues
2.5 This year’s recommendations
In 2006 several reports were issued by the Suffolk Directors of Public Health in which the following topics were covered:

- Health inequalities
- Educational achievement and deprivation
- Mental health
- General public health issues

2.1 Health inequalities

In 2006, the Directors reported on health inequalities in death rates under age 75 across the whole county of Suffolk. From this information we were able to pinpoint those parts of the county with the highest and lowest death rates. The main findings were that:

- There has been an encouraging decline across Suffolk in death rates over the last 25 years but the available evidence suggests this decline has been slower in more deprived areas, thus increasing relative inequalities.
- The areas that had the highest death rates a decade ago still have them now.
- There are high death rates in relatively large areas of Ipswich and Lowestoft and high death rates in smaller areas in Newmarket, Bury, Haverhill and Sudbury. However, about half of all under 75 deaths occur outside the major towns.
- The area covered by the Town and Bridge Project in Ipswich has the highest under 75 death rate in Suffolk.

The main recommendations were that:

- The NHS and local government need to support general approaches to tackle health inequalities in Suffolk but focus initial action on preventing early death rates in deprived urban communities.
- Local Strategic Partnerships (LSPs) and the Local Area Agreement need to focus on our most disadvantaged communities.
- The Town and Bridge Project needs to be supported by the new Suffolk PCT and local government.

The following progress has been made:

- Suffolk PCT, Great Yarmouth and Waveney PCT and Suffolk County Council have agreed to tackle health and social inequalities through a joint health and wellbeing strategy to be approved in early 2008.

The strategy will recommend those measures that will prevent early deaths and improve health in deprived communities, for example by specifically considering the potential impact of expanding community development programmes in discrete deprived areas.

- New targets will be set for the Local Area Agreement in June 2008 and health inequalities are expected to be a major issue.
- Suffolk PCT has identified a recurrent sum of money, rising to £100,000 in the financial year 2009-10, to support the activity of the Town and Bridge Project.
2.2 Educational achievement and deprivation

In 2006, we reported on educational achievement at key stages (KS) 2 and 3, at GCSE and at A level in all the 175 Local Authority wards in Suffolk. Achievement data is often analysed in relation to schools and this is the data that is regularly published in league tables of school results. We tried to find out if other factors (notably income levels in houses with children) were associated with educational achievement between ages 11 and 18. Most of the achievement data related to the four years 2002-2005.

The main findings were that:

- There was a very significant association between achievement and household income. Achievement levels rose as the proportion of families with children that were dependent on income support fell.
- This association was strong at KS2, KS3 and GCSE. It was less marked at A level but still present – although the A level information was based on just one year of data.
- The difference in performance between the group of most deprived and the group of least deprived wards widened in the three years between KS2 exams (taken in year 6) and KS3 exams (taken in year 9).
- Far fewer young people from the most deprived wards stayed on for A levels when compared with those from less deprived wards.

The main recommendation was that:

- Suffolk County Council as the local education authority (LEA) lead a piece of work with other key partners to explore these issues and find out what can be done to address them – starting with a review of the available literature, then developing and implementing an action plan. The County Council should continue to monitor educational attainment in order to track the success of its initiatives.

The strong correlation between low income households and poor educational attainment was identified by a government report in 2004. The Department for Education and Skills (DfES) then asked all local education authorities to review the way they allocated budgets to their schools to ensure that proper account was taken of relative levels of deprivation.

The following initiative is underway:

- As part of Suffolk’s review of the funding allocation formula for its primary, middle and
high schools, various options were developed for targeting extra funding to schools with higher proportions of pupils from poorer households. The consultation period on possible changes has just ended, and there was strong support for significantly increasing the financial support for schools, based on a new measure of socio-economic deprivation. Changes are likely to be introduced from April 2008 and the authority will monitor the impact on attainment over the next few years.

In addition, the health and wellbeing strategy (see 2.1 above) will address this as an area of concern.

2.3 Mental health

In 2006 the main findings were that:

- Mental health problems continue to be a major cause of illness affecting as many as 1 in 6 adults at any one time.
- A variety of factors play a part and mental health varies according to age, sex, ethnicity, socio-economic status, employment and education.
- The links between mental ill health and deprivation and urban environment were clear in all age groups. The importance of mental ill health in the prison environment was also highlighted.
- A significantly higher proportion of those seen and admitted to specialist mental health services classed themselves as coming from ethnic minority groups.
- There was a clear link between poorer mental and poorer physical health.
- All GPs in Suffolk had registers for those with severe mental illness and the majority proactively monitored physical health in this group. However some registers were felt to be incomplete and there was a lot of variation between practices.
- Information collection within Suffolk Mental Health Partnership Trust (SMHPT) had improved from the last analysis in 1991.
- Suicide was a preventable cause of death (based on information from annual suicide audits).
The main recommendations were that:

- Commissioners and providers need to ensure that mental health services are available to meet the needs of ethnic minorities and also the needs of prisoners.

- Monitoring physical health is very important in those with severe mental illness. SMHPT should continue their progress in this area.

- General practice registers for severe mental illness should become more comprehensive.

- Further improvements in information collection within SMHPT were necessary if the Trust and commissioners were to ensure that service delivery was equitable across the population.

- Continued action was needed to prevent suicide in the community.

The following progress has been made:

- The mental health needs of prisoners are being reviewed and improvements have been suggested in the way services are delivered.

- SMHPT agreed a Single Equality Scheme in April 2007, has improved ethnic monitoring and developed links with minority ethnic communities and faith communities. Staff training has taken place and information in different languages is being produced.

- The 2006/07 Quality Outcomes Framework (QOF) data shows a substantial increase in the number of people on GP psychosis registers – the total register for Suffolk PCT is now 3,833 which is an increase of 76.6% from last year, suggesting people with psychosis are being more comprehensively registered.

As well as the large increase in the number of people on the registers, there has also been a slight improvement in the percentage of those who have been seen for annual review (from 80% to 84%), but there is still large variation between practices.

- The PCT has required the Mental Health Partnership Trust to deliver improved data through the commissioning process and the improvements are being monitored.

- A multi-agency suicide prevention strategy has been developed.

However,

- Despite the strengthening of mental health commissioning in Suffolk PCT, the specific needs of the deprived communities have not as yet been addressed.

- The Local Area Agreement (LAA), which helps focus partnership work across agencies, currently does not highlight the needs of those with mental health problems. Work is currently on-going to create a new LAA target addressing mental health.

- Further work is needed to develop a mental health promotion strategy to promote good mental health and reduce the discrimination and social exclusion associated with mental health problems.

- The recent Suffolk Children and Young People’s Joint Area Review identified some good practice in mental health care, but this was not universal. Suffolk needs to develop robust transition processes for young people with mental health problems.
2.4 General public health issues

In 2006 the main findings were that:

- More comprehensive knowledge was needed to plan local health services and the need for a coherent information strategy emphasised.
- The health of the population of Suffolk was generally good, but there is considerable geographic variation for important causes of death such as cancer and heart disease. The contribution of lifestyle (especially smoking) in causing early deaths was highlighted.
- Not enough children were vaccinated against measles, mumps and rubella at age two.
- There was continuing national concern about healthcare acquired infection, although rates of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia locally were relatively low.
- Women’s uptake of cervical screening was generally good, but uptake was relatively low in some general practices serving more deprived communities and in younger age groups.
- There was considerable variation in emergency admission rates by age and by general practice.
- The health of staff in Suffolk West Primary Care Trust was an area which needed to be reviewed as the PCTs were about to be replaced by a new organisation, Suffolk PCT.

The main recommendations were that Suffolk PCT should:

- With partner agencies, develop plans to tackle smoking, obesity, improve mental health and encourage sensible drinking.
- Designate one of its board members as a ‘Chief Knowledge Officer’ so that an appropriate information strategy could be implemented.
- Ensure its commissioning is driven by robust information, so services for health represent the best value for money.
- Consider how to improve screening uptake where coverage rates are low.
- Continue to raise awareness of the importance of MMR vaccination.
- Continue to work with partners to ensure a robust approach to preventing healthcare acquired infection.

The following progress has been made:

- A dedicated project has been established across Suffolk PCT, Great Yarmouth and Waveney PCT and Suffolk County Council to decide the best approach to
Progress on the recommendations in the 2006 reports of the Suffolk Directors of Public Health

Managing information. A joint strategic needs assessment will be undertaken and completed in 2007, which will allow systematically collected knowledge to be used directly in decision-making.

- Plans for tackling smoking and childhood obesity have already been implemented.
- Plans for tackling adult obesity, improving mental health and encouraging sensible drinking will be completed in the next 6 months and form part of the health and wellbeing strategy (see 2.1 above).
- MMR (measles, mumps and rubella) vaccination has retained a high profile. Details on progress are given in this report.
- Healthcare acquired infection rates (especially MRSA) have remained at relatively low levels locally. The PCT Board has recently approved an infection control policy which details a comprehensive range of actions which aim to systematically reduce the number of local people with healthcare acquired infection.

- Some initial work has been started to improve cervical screening uptake, including a project to improve screening uptake by women with learning disabilities.
- A new nurse-led Occupational Health Service has been commissioned for PCT staff for 2007/8 onwards, offering a more flexible and accessible service at various locations in the PCT. Staff who have a problem can access Occupational Health by self referral, via their line manager or via Human Resources.

However,
- Recorded staff sickness increased during, and after, the period of PCT reorganisation in 2006/07. The total figure for the previous PCTs in quarter 1 of 2005/06 was 4.95%, compared to 5.6% for the new Suffolk PCT in the same quarter of 2006/07. There are two reasons for the increase:
  - The first is the impact of the changes that were taking place in 2006/07. These changes affected all staff groups.
  - The second is that the process for accurately recording and reporting staff sickness was improved between the two time periods.

2.5 This year’s recommendations

1. It is recommended that a landmark event is organised with Suffolk Children’s Trust, which will build on current work.

Urgent measures now need to be taken to:

- Improve vaccination rates for measles, mumps and rubella.
- Prevent unhealthy lifestyles in childhood, particularly childhood obesity, risky sexual behaviour and inappropriate alcohol consumption.
- Promote healthy lifestyles in school.
- Prevent accidents.
- Improve the health, educational and social status of homeless children and children who are carers.

The landmark event should bring together NHS, local government, voluntary and business sectors to discuss the future of the health of Suffolk’s children and young people. The result of this event would be a clear action plan to improve the health of children and young people.

*Suffolk is moving towards a radically different way of planning and providing services for children through a Children’s Trust, which brings together all agencies responsible for children and young people.
people in Suffolk so that they can compare with the best in Europe.

The principles underpinning the event should be that:

- The contribution of all services in improving the health of children and young people in Suffolk is recognised. For example, the Children and Adolescent Mental Health Services (CAMHS) commissioning model, the Suffolk Healthy Schools Programme and the Maternity Services review.

- All services give clear and consistent messages about healthy lifestyles and these are made fully accessible to children, young people and their families.

- Support is given to children, young people and their families so they find it easier to access services to improve their health, and all relevant services see this as a core activity.

- There is full engagement with the public including discussion about future priorities.

- The impact of the environment and other factors affecting the lives of children and young people should be considered.

- The reduction of geographic, social and educational inequalities is seen as paramount.

2. Good data is needed to monitor and promote health and wellbeing and this report has identified many areas where this data is incomplete.

   a. It is recommended that a ‘Chief Knowledge Officer’ is identified for Suffolk PCT and Suffolk CC to inform the PCT Board and County Council Cabinet on whether information is systematically made available to improve the population’s health through a joint information strategy.

   b. It is recommended that Suffolk County Council and Suffolk PCT implement specific plans to improve data about lifestyles, breast feeding, smoking in pregnancy, accidents and the needs of vulnerable groups through the Joint Strategic Needs Assessment.

3. Outstanding recommendations from Directors’ of Public Health reports in 2006 should be re-visited and appropriately acted upon.
Health profile of children and young people in Suffolk

3.1 Population and population change
- Ethnic Minority groups in the Suffolk population
- Births in Suffolk and life expectancy
- Deaths of children and young people in Suffolk

3.2 Child health in Suffolk
- Protection from infectious diseases
- Dental health
- Children’s own views about their health
- Smoking and alcohol
- Teenage pregnancies
- Emotional wellbeing and mental health

3.3 Wider determinants of health
- Education
- Economic prosperity
- Children and known disadvantages
- Children and crime
3.1 Population and population change

In 2005 the estimated population in Suffolk of children and young people aged 0 to 19 years was 165,670, which represents 24.4% of the total population and is very close to the figure of 24.5% in England and Wales. There is some variation between the Suffolk local authorities from 23.3% in St Edmundsbury to 25.4% in Ipswich. Whilst the total population of England and Wales and each of the Suffolk local authorities (except Forest Heath) has risen over the years 1995 to 2005 (by 6.2% in Suffolk and 4.1% in England and Wales), changes in the numbers of children and young people varied considerably, with a percentage decrease across Suffolk in those aged 1 to 4 years and 5 to 9 years (see Figure 1). Population projections show that between 2005 and 2025 the total population of Suffolk is expected to rise by 14.1% which is 5.5% more than the projection for England and Wales. The numbers of children and young people in Suffolk as a whole however, are expected to rise by only 1%, and there is expected to be a decrease in all the Suffolk local authority areas except Forest Heath and St Edmundsbury (see Table 1).

![Figure 1: Children and Young People Population Estimates - Suffolk Local Authorities 2005](image)

<table>
<thead>
<tr>
<th>Local Authorities</th>
<th>1-4 yrs</th>
<th>5-9 yrs</th>
<th>10-14 yrs</th>
<th>15-19 yrs</th>
<th>0-19 yrs</th>
<th>All ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>7.7%</td>
<td>-2.4%</td>
<td>-5.6%</td>
<td>-6.0%</td>
<td>-2.1%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>57.4%</td>
<td>70.3%</td>
<td>48.9%</td>
<td>6.0%</td>
<td>46.6%</td>
<td>23.1%</td>
</tr>
<tr>
<td>Ipswich</td>
<td>6.1%</td>
<td>0.5%</td>
<td>-9.6%</td>
<td>-13.7%</td>
<td>-4.6%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>3.0%</td>
<td>-4.0%</td>
<td>-4.4%</td>
<td>-7.9%</td>
<td>-3.5%</td>
<td>14.7%</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>7.5%</td>
<td>5.2%</td>
<td>2.1%</td>
<td>-3.7%</td>
<td>2.8%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>-0.6%</td>
<td>-11.1%</td>
<td>-15.8%</td>
<td>-16.2%</td>
<td>-11.7%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Waveney</td>
<td>8.9%</td>
<td>1.7%</td>
<td>-4.2%</td>
<td>-7.6%</td>
<td>-0.9%</td>
<td>17.4%</td>
</tr>
<tr>
<td>Suffolk</td>
<td>11.9%</td>
<td>4.4%</td>
<td>-2.5%</td>
<td>-8.4%</td>
<td>1.0%</td>
<td>14.1%</td>
</tr>
<tr>
<td>England and Wales</td>
<td>4.0%</td>
<td>0.8%</td>
<td>7.4%</td>
<td>-10.1%</td>
<td>-3.5%</td>
<td>8.6%</td>
</tr>
</tbody>
</table>

Source: ONS
The variable nature of these figures will make planning health and education services in particular, very difficult across the county.

**Ethnic minority groups in the Suffolk population**
Compared with other areas of the UK, the numbers of people from minority ethnic groups living in Suffolk is relatively small, but this makes it all the more important that their special needs should not be overlooked in planning health and social care. The numbers of children from minority ethnic groups entering Suffolk schools shows a percentage increase in all groups, although the actual numbers for some is small (see Table 2). This data may not be entirely accurate and should be treated with caution, but does give some indication of the children who need special consideration. For example, 620 children enrolled in Suffolk schools since September 2006 had a first language other than English, with 31 other languages recorded. Overall, more than 105 languages have been recorded as a first language used by pupils in Suffolk schools.

**Births in Suffolk**
Even in the 21st century UK, the events surrounding fetal development and birth are still amongst the most critical in an individual’s life. Information about births and birth rates not only tell us what we need to know about future growth in the population and need for services, but also about the probable future health and well-being of children and young people in the next generation.

**Fertility rate**
The local fertility rates are one of the indicators of future need for maternity services, children’s health services and schools. The fertility rate in England reached an all time low in 2001, but since then has been steadily rising. In Suffolk the average total period fertility rate (TPFR)\(^2\) for the years 2003-2005 is 1.88, and is higher than for England (1.77) in each of the local authority areas except for Forest Heath (range 1.73 – 1.95) (see Figure 2). The reasons for these higher rates are not clear, and are likely to be due to complex health and social factors. These fertility rates still

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**Table 2: Key minority ethnic groups in Suffolk schools 2003-2007**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladeshi</td>
<td>386</td>
<td>546</td>
<td>42%</td>
</tr>
<tr>
<td>Indian</td>
<td>195</td>
<td>436</td>
<td>124%</td>
</tr>
<tr>
<td>Any other Asian background</td>
<td>138</td>
<td>319</td>
<td>131%</td>
</tr>
<tr>
<td>Caribbean</td>
<td>298</td>
<td>236</td>
<td>-21%</td>
</tr>
<tr>
<td>Chinese</td>
<td>206</td>
<td>255</td>
<td>24%</td>
</tr>
<tr>
<td>Any other mixed background</td>
<td>804</td>
<td>976</td>
<td>21%</td>
</tr>
<tr>
<td>White and Asian</td>
<td>217</td>
<td>298</td>
<td>37%</td>
</tr>
<tr>
<td>White and Black African</td>
<td>167</td>
<td>263</td>
<td>58%</td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>741</td>
<td>964</td>
<td>30%</td>
</tr>
<tr>
<td>White Eastern European</td>
<td>7</td>
<td>14</td>
<td>100%</td>
</tr>
<tr>
<td>Traveller of Irish heritage</td>
<td>24</td>
<td>27</td>
<td>13%</td>
</tr>
<tr>
<td>Any other white background</td>
<td>1465</td>
<td>1876</td>
<td>28%</td>
</tr>
<tr>
<td>Portuguese</td>
<td>3</td>
<td>19</td>
<td>533%</td>
</tr>
<tr>
<td>Gypsy/Roma</td>
<td>43</td>
<td>109</td>
<td>153%</td>
</tr>
</tbody>
</table>

Source: PLASC (Schools Census 2007) and Suffolk County Council Children and Young People’s Services Performance Handbook 2007

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\(^2\)Total period fertility rate (TPFR) is the hypothetical number of children an average woman would produce in her lifetime if current fertility rates continued. This is calculated for women aged 15 to 44 years, and standardised for the age structure of the population. (ERPHO, 2006, Investigation into the fertility rate increase. INPHO Issue 21.)
do not reach the ‘replacement rate’ of 2.1 children per woman, and so inward migration will be needed to stop the population declining.

**Numbers of babies and life expectancy**

According to the World Health Organisation (WHO) in 2004, the live birth rate in the UK was 12 per 1,000 population. Compared with Europe, only 13 of 53 states had higher rates, including Norway, France, Iceland, Ireland and Israel, the others being former Eastern Bloc countries.

Life expectancy is a general indicator of the population’s health, and is very different for these babies at birth, with a baby born in the UK having a life expectancy of 79 years compared with a baby born in Kazakhstan with a life expectancy of 65.9 years. The highest life expectancy in Europe was in San Marino at 82.3 years, demonstrating the considerable health inequalities across Europe. Even within the UK variations in life expectancy reveal major health inequalities. Life expectancy in Suffolk is generally higher than in England, with figures of approximately 78 years for a boy born now in Suffolk and 83 years for a girl, but there is a significant difference in all the Local Authorities between the most and least healthy wards. In St Edmundsbury this difference is 10.1 years even when the extremely high rate for Moreton Hall (reflecting its unusually young population), has been excluded (see Table 3).

In 2005, 7,493 babies were born in Suffolk, 56% of them to women aged between 25 and 34 years, 15.2% to women aged 35 to 39 years and just 3.3% to women aged 40 years and over. Compared with the rest of Europe, a higher proportion of babies in the UK are being born to women over the age of 35 years; only seven of 53 states had higher rates than the UK, including Ireland, Germany, Spain and Sweden. This national trend suggests that women are delaying starting a family, and if this is true for women across Suffolk there will be implications for services because of difficulties with infertility and complications of...
pregnancy associated with increasing age.

Deaths of children and young people in Suffolk
The death of a child over the age of one year is now a relatively rare event, but sadly in Suffolk from 2003 to 2005, 90 children died between the ages of one year and 19 years, 50 of them between 15 and 19 years. Forty of these deaths were the result of accidents, and of these 29 were young men aged 15 to 19 years. Protection from infectious diseases
In the past infectious disease was a major cause of death and life long disability in children, but there are now effective immunisation and vaccination programmes against many of these diseases. However, in order to prevent outbreaks of the infectious diseases common in childhood, a large proportion of the community has to be immunised or vaccinated for there to be 'herd immunity'. If this level drops too low, it becomes possible for disease to spread and unprotected children are vulnerable to the disease. Concern amongst parents in recent years about the safety of some vaccines has led to a decline in uptake, and there have been intensive public health campaigns to encourage parents to have their children immunised.

3.2 Child health in Suffolk
We know that poor health in childhood can persist into adulthood, and it is therefore important to understand the factors that affect the health of children and young people, and how to improve their health and wellbeing to give them the best possible launch into adulthood.

Protection from infectious diseases
In the past infectious disease was a major cause of death and life long disability in children, but...
95% of all children. Although the levels of immunisation required for herd immunity differ with different infections, it is generally accepted that an 85% coverage rate should be aimed for.

The Suffolk figures below (see Figure 3) are comparable with the national pattern of MMR coverage, and although rates appear to have recovered for the first MMR immunisation given at 13 months of age, rates for the pre-school MMR booster remain a serious concern. This is being investigated further by Suffolk PCT. The figures may be low because children really have not been immunised against measles, mumps and rubella, or it could be that a significant number have had the single antigen vaccines administered privately, in which case there would be no record on the Child Health System, or that for some other reason there is under reporting of MMR immunisations.

<table>
<thead>
<tr>
<th>Figure 3: MMR percentage take up rates, by former PCT area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ipswich PCT</td>
</tr>
<tr>
<td>2002</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>2004</td>
</tr>
<tr>
<td>2005</td>
</tr>
<tr>
<td>2006</td>
</tr>
<tr>
<td>Suffolk Coastal PCT</td>
</tr>
<tr>
<td>2002</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>2004</td>
</tr>
<tr>
<td>2005</td>
</tr>
<tr>
<td>2006</td>
</tr>
<tr>
<td>Central Suffolk PCT</td>
</tr>
<tr>
<td>2002</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>2004</td>
</tr>
<tr>
<td>2005</td>
</tr>
<tr>
<td>2006</td>
</tr>
<tr>
<td>Waveney PCT</td>
</tr>
<tr>
<td>2002</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>2004</td>
</tr>
<tr>
<td>2005</td>
</tr>
<tr>
<td>2006</td>
</tr>
<tr>
<td>Suffolk West PCT</td>
</tr>
<tr>
<td>2002</td>
</tr>
<tr>
<td>2003</td>
</tr>
<tr>
<td>2004</td>
</tr>
<tr>
<td>2005</td>
</tr>
<tr>
<td>2006</td>
</tr>
</tbody>
</table>
Change in the childhood immunisation schedules 2006/07

New preventive measures become widely available so that immunisation schedules have to be kept constantly under review. Changes to the UK national schedule for children this year include:

- a booster dose against meningitis C and HIB at 12 months of age
- introduction of a conjugate vaccine against invasive pneumococcal infection for all children at 2 months of age and 4 months of age, with a booster at 13 months.

Previously there was an effective vaccine only for adults, but a children’s version has now been developed, and a ‘catch up campaign’ was run across the county from September 2006 to March 2007. It is expected that pneumococcal disease in the whole community will gradually decrease. In particular this will benefit children up to the age of 2 years who are most susceptible to meningitis, septicaemia and ear infections caused by the pneumococcus, and the very elderly who are most susceptible to pneumococcal chest infections.

Dental health

Dental health is not only a good marker of general health in children and may be associated with other forms of health and social disadvantage, but in itself is also a cause of health related difficulties throughout life. The latest figures for Europe show that the United Kingdom has the lowest rate of decayed, missing or filled teeth (dmft) for 12 year olds. Of the previous PCTs in Suffolk, in the academic year 2003/04 only Ipswich had as high a percentage of children with dental decay at 5 years of age, as England as a whole. The latest figures for 5 year olds with dmft show that Suffolk compares well with England as a whole, but constant changes in NHS boundaries make it impossible to do comparisons over time, even at the regional level (see Table 4).

It should be noted that the mean rate of decayed, missing or filled teeth for all children in Suffolk is 0.87 in 2005/06, whereas for those children who have dental decay, the mean rate of decayed, missing or filled teeth is 3.16. This means that for the children who do have dental decay, it is a serious health problem.

Dental caries experience of 5-year-old children in Great Britain 2005/06

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>38.0%</td>
</tr>
<tr>
<td>East of England</td>
<td>32.1%</td>
</tr>
<tr>
<td>Great Yarmouth and Waveney PCT</td>
<td>39.1%</td>
</tr>
<tr>
<td>Suffolk PCT</td>
<td>27.4%</td>
</tr>
</tbody>
</table>

Source: Surveys co-ordinated by the British Association for the Study of Community Dentistry
Children’s own views about their health
When asked how they felt about their health in the 2007 TellUs Survey, 84% of pupils in years 8 and 10 described themselves as healthy or fairly healthy whilst 91% described their life as fairly enjoyable. The majority report that they hardly ever smoke cigarettes, drink alcohol or take illegal substances and they exercise regularly. However, 62% said they sometimes felt stressed and 15% identified that they were stressed almost all of the time.

Nine percent of children who report their life not being enjoyable is very significant in the commissioning of services that will contribute to reducing health inequalities. (SCC 2007)

Children, smoking and alcohol
Although the majority of children may not smoke, a national survey in 2004 (Fuller, 2005) showed that 9% of 11 to 15 year olds smoke regularly, and amongst 14 and 15 year olds, girls are more likely to smoke than boys. Exposure to second hand tobacco smoke has been shown to be linked to adverse health effects and it has been estimated that this affects about 1 in 3 children in England. This has also been shown to be associated with deprivation, and is yet another cause for concern about the health of disadvantaged children in Suffolk.

The 2002 Health Survey for England showed that by the age of 15 years 87% of boys and 86% of girls said that they had had an alcoholic drink. More children between the ages of 8 to 15 years said that they had had an alcoholic drink at least a few times in the year in the Eastern Region (EoE) than in any of the other regions of England (48% boys and 42% of girls EoE, 40% and 36% England). Consumption of alcohol is shown to increase with age, and as the increase in alcohol intake in girls is faster than that in boys, the gap between them is decreasing. This is of great concern as children and young people become vulnerable to the diseases associated with alcohol consumption, to accidents and to criminal and antisocial behaviour.

Teenage pregnancies
Teenage pregnancies continue to be a concern both nationally and locally, as there is potential lifetime disadvantage for both the young mother and her baby. Across Europe, rates of teenage pregnancy vary widely, from Switzerland showing that 1.1%
of all live births are to women under the age of 20 years, to Bulgaria with 15%. The equivalent UK figure was 7.1%, with only the former Eastern Bloc countries having higher rates. Even though a proportion of these pregnancies will have been intended, the causes of these high rates in the UK need to be better understood before effective interventions can be implemented.

In 2005 in Suffolk, there were 9 births to girls between the ages of 11 and 15 years, and 452 babies born to girls between the ages of 16 and 19 years. Although the teenage pregnancy rates in Suffolk are lower than in England as a whole, between the years 2002 to 2004 the rate for girls aged under 18 years has fallen a little annually within England, but it has stayed much the same in Suffolk. This is an issue that needs to be kept under constant review (see Figure 4).

Emotional wellbeing and mental health.
There is increasing recognition of the need to support the emotional health and wellbeing of all children from birth onwards. It is estimated that between 10% and 20% of children and young people may experience some mental health problems, and that early identification and appropriate support will help to divert many away from the need for specialist interventions.

In Suffolk, work is ongoing to meet the recommendations of the ‘Birth to Three Matters’ framework, and the Suffolk Healthy Schools Programme is working to promote the importance of emotional wellbeing. Implementation of the Children and Adolescent Mental Health Service’s strategy 2006-2009 aims to improve access to services, including services for those with learning disabilities. The service will also be linked with Children’s Centres and schools, to offer support and training for staff as well as services for families, children and young people.

Children and play
Although children today appear to have many and varied choices in their leisure time activities, their opportunities and freedoms to play as they choose may be far more limited than those of their
parents and grandparents. Low levels of physical activity are resulting in children becoming overweight and obese. Play also has a role in children's emotional and social wellbeing and development, and encourages creativity and independence. Partners in Play (PIPS) is a Suffolk wide group which is developing a play strategy for the county. The group aims to promote and support the provision of play opportunities for children and young people at local levels across the county. Access to play space and opportunities to use it may be particularly difficult for children in some of the rural parts of the county, as well as for children in urban areas. Suffolk’s local authorities are consulting children and young people, and working to increase the variety and access to play provision for all children in the county.

3.3 Wider determinants of health

A range of factors contribute to the health of all individuals and are known as the wider determinants of health (Dahlgren & Whitehead, 1991). These include:

- Age, sex and hereditary factors
- Individual lifestyle factors
- Social and community influences
- Living and working conditions
- General socio-economic, cultural and environmental conditions

Children and young people are healthier than ever before and death is rare. However, children are very vulnerable to social and environmental conditions within the household and wider community, and disadvantage in childhood compounds problems experienced in later life. A significant minority of children and young people in Suffolk face damaged childhoods, disaffection, underachievement and social exclusion. The outcomes and life chances for these children compared to the successful majority is too wide. For example, we know that two thirds of three year olds with disturbed behaviour still have significant difficulties at the age of 12 (Campbell, 1995). Although relative disadvantage and deprivation may be easier to identify in the more urban areas of the county, we know that rural poverty is also a problem in Suffolk, and different means will have to be found to tackle these problems.

Education

Education is recognised as one of the most significant factors in the life of a child or young person. Adults may say their lifetime achievements are either the result of, or in spite of their
experience of formal education. We therefore need to know what happens to Suffolk’s children at school and how it equips them for adult life.

Table 5 shows that although results at Key Stage 2 are improving across Suffolk, they are not improving uniformly across the local authority areas, and the percentage differences between the best and worst performing areas have not changed between 2001 and 2006. Similarly, GCSE attainment has improved across the county over the same time period, but improvements have been more marked in some areas than others, and significant differences remain, with the poorest results still to be found in the areas with the greatest degree of deprivation on other measures (see Table 6).

---

**Table 5: Primary School Attainment - KS2 (age 11 years)**

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>82.8</td>
<td>81.6</td>
<td>80.3</td>
<td>82.8</td>
<td>83.2</td>
<td>81.4</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>78.4</td>
<td>78.4</td>
<td>77.7</td>
<td>79.7</td>
<td>79</td>
<td>81.3</td>
</tr>
<tr>
<td>Ipswich</td>
<td>74.7</td>
<td>75.7</td>
<td>75.3</td>
<td>77.9</td>
<td>78.4</td>
<td>78.5</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>80.2</td>
<td>79.5</td>
<td>80.3</td>
<td>84.3</td>
<td>83.2</td>
<td>86.8</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>76.6</td>
<td>74.8</td>
<td>77</td>
<td>77.7</td>
<td>76.2</td>
<td>81.8</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>82.3</td>
<td>80.4</td>
<td>81</td>
<td>80.2</td>
<td>80.5</td>
<td>83.2</td>
</tr>
<tr>
<td>Waveney</td>
<td>72.9</td>
<td>70.8</td>
<td>73.3</td>
<td>71.1</td>
<td>75.7</td>
<td>75</td>
</tr>
<tr>
<td>Suffolk</td>
<td>77</td>
<td>76.1</td>
<td>76.8</td>
<td>77.7</td>
<td>78</td>
<td>79.4</td>
</tr>
</tbody>
</table>

Source: Suffolk Observatory

---

**Table 6: GCSE Attainment - Year 11**

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>64.1</td>
<td>68.1</td>
<td>66.1</td>
<td>66.6</td>
<td>66.1</td>
<td>68.7</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>43.4</td>
<td>47.5</td>
<td>56.6</td>
<td>59.3</td>
<td>59.6</td>
<td>58.8</td>
</tr>
<tr>
<td>Ipswich</td>
<td>48.3</td>
<td>50.7</td>
<td>53.8</td>
<td>63.5</td>
<td>65.6</td>
<td>59.7</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>57.9</td>
<td>58.7</td>
<td>61.6</td>
<td>55.4</td>
<td>57.7</td>
<td>61</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>59.4</td>
<td>62.5</td>
<td>63.8</td>
<td>65</td>
<td>67.4</td>
<td>69.5</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>62.7</td>
<td>65.5</td>
<td>71.5</td>
<td>66.1</td>
<td>68.1</td>
<td>67.3</td>
</tr>
<tr>
<td>Waveney</td>
<td>47.8</td>
<td>49.2</td>
<td>52.5</td>
<td>50.2</td>
<td>50.7</td>
<td>53.4</td>
</tr>
<tr>
<td>Suffolk</td>
<td>54.3</td>
<td>56.5</td>
<td>57</td>
<td>57.3</td>
<td>61.9</td>
<td>62.8</td>
</tr>
</tbody>
</table>

Source: Suffolk Observatory

---

Academic attainment is not the only measure of success in education. In a survey in 2005 of Suffolk children and young people aged 11 to 17 years, 27.6% agreed with the statements that bullying was a big problem in their school, and 58.1% that there was bullying going on that staff don’t notice. 43.2% did not agree with the statement that ‘everyone in my school is treated fairly and with respect’, but perhaps more encouragingly, 41.2% agreed that they would feel confident reporting someone who was bullying other pupils at school. This was from a sample of only 678 young people, but it highlights the significance the school experience has for children’s overall wellbeing.

Education aims to enable children and young people to...
reach their full potential and to prepare them to take an active part in the adult world. Table 7 shows that 525 or 6.8% of all 16 year olds in Suffolk left school in 2006 without going on to some form of education, employment or training (NEET). At A-level, the average points score per candidate rose between 2004 and 2005, but between 2002 and 2006 the percentage of 18 year olds going on to higher education shows a variable pattern. Figures for Waveney and Forest Heath districts are consistently lower than other areas of the county. (SCC 2007; Suffolk Observatory).

Economic prosperity
Suffolk is known for its prosperous towns and villages, thriving agricultural industry and as an attractive county for tourists. Unemployment in Suffolk is low compared with England, at 5.0% compared with 5.4% in 2003. However, this hides variation across the county as Waveney had an unemployment rate of 9.1% and Suffolk Coastal a rate of only 3.3%. (NOMIS 2007). Many jobs are low paid with poor opportunities, and Suffolk has a skills profile lower than the national average, with 15.8% of the working age population with no qualifications compared with 14.1% in England. Again, there are major differences across the county with 21.5% and 19.8% of the working age populations of Forest Heath and Waveney respectively having no qualifications. Table 8 shows that the average wage in Suffolk is lower than both the national and regional averages, with lower rates of increase.

Table 7: Young people's destinations at age 16 years 2006

<table>
<thead>
<tr>
<th>Area</th>
<th>Sixth Form</th>
<th>Further Education</th>
<th>NVQ2</th>
<th>Govt. training scheme</th>
<th>Employment not NVQ2</th>
<th>NEET</th>
<th>No Response</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>432</td>
<td>45.4</td>
<td>329</td>
<td>34.6</td>
<td>15</td>
<td>66</td>
<td>6.9</td>
<td>952</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>220</td>
<td>46</td>
<td>120</td>
<td>25.1</td>
<td>3</td>
<td>53</td>
<td>11.1</td>
<td>478</td>
</tr>
<tr>
<td>Ipswich</td>
<td>627</td>
<td>40.9</td>
<td>545</td>
<td>35.6</td>
<td>31</td>
<td>90</td>
<td>5.9</td>
<td>1532</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>528</td>
<td>51.1</td>
<td>289</td>
<td>28</td>
<td>19</td>
<td>75</td>
<td>7.3</td>
<td>1033</td>
</tr>
<tr>
<td>St. Edmundsbury</td>
<td>505</td>
<td>46.1</td>
<td>378</td>
<td>34.5</td>
<td>10</td>
<td>71</td>
<td>6.5</td>
<td>1096</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>820</td>
<td>60.8</td>
<td>328</td>
<td>24.3</td>
<td>5</td>
<td>58</td>
<td>4.3</td>
<td>1348</td>
</tr>
<tr>
<td>Waveney</td>
<td>634</td>
<td>47.7</td>
<td>445</td>
<td>33.5</td>
<td>24</td>
<td>76</td>
<td>5.7</td>
<td>1330</td>
</tr>
</tbody>
</table>

Source: Suffolk Observatory
In England in 2003, 13.9% of the working age population were receiving a key social security benefit, and in Suffolk the figure was 10.2%. The percentage in both Ipswich and Waveney however, was 14.8%, revealing yet again that although Suffolk appears to be prosperous, significant areas of the county fare worse than England as a whole. These mixed fortunes in economic prosperity have serious consequences for the county’s children and young people as it means that many of them are growing up not only with the disadvantages associated with the insecurity and relative poverty of low income, but also in communities where expectations and aspirations for achievement in adult life are low.

### Children and known disadvantages
The recent Suffolk Children and Young People’s Performance Handbook (SCC 2007) provides important information about children and young people in Suffolk who are known to be disadvantaged in one way or another. For example there are approximately 700 ‘Looked After Children’ for whom the county council has a statutory parenting role, and around 400 children on the child protection register. These figures are similar to the national average, but are higher than other areas of the country similar to Suffolk. There are also 7,500 children with disabilities, and approximately 18,000 children with some kind of Special Educational Need. In 2006, there were 129 young people under the age of 18 years who were providing care for another family member, and who were themselves being supported by the Young Carers Project. This is likely to be only a small percentage of the total number of children and young people providing care to parents and siblings.

### Crime
Approximately 2,000 young people are under the supervision of the Youth Offending Service. The most common types of crime committed by young people are...
violent crime, criminal damage and theft from shops, with the number of offences increasing with age, to a peak at 15 to 16 years. Sixteen years of age is also the most common age for a young person to be the victim of crime. Being an offender or a victim puts a young person at a disadvantage, and the reduction of criminal behaviour requires co-operative action from many statutory and voluntary agencies across the county.

References

Annual population survey 2003 ONS Crown Copyright (from Nomis accessed on 18 July 2007)


Suffolk County Council (2007), Suffolk Children and Young People’s Services Performance Handbook
4

Services for children and young people

4.1 Maternity care in Suffolk
   - Maternity statistics
   - Maternity services

4.2 Low birthweight babies

4.3 Working in partnership for children and young people

4.4 Use of hospital services by children
   - Children and hospital admission
   - Children and accidents

4.5 Services for Looked After Children
   - The role of health services
   - The role of Children and Young People’s Services

4.6 Children who are homeless

4.7 The future of health visiting and school nursing
4.1 Maternity care in Suffolk

The maternity services work with people who are relatively young, are experiencing a normal and positive life event, and are usually healthy. However, women can suffer conditions in the course of pregnancy and childbirth which are life threatening or may leave them with serious morbidity. Women with pre-existing long term conditions can now deliver safely, but only with integrated care from expert obstetricians and physicians. The first few hours of life are considered to be the most critical, with the care a baby receives around the time of delivery being of paramount importance, whether it occurs in an acute hospital, birthing unit or at home.

Maternity statistics

Maternal mortality

Maternal mortality is a mercifully rare event now in the UK, but nevertheless, between 2003 and 2005, 128 women in England, of whom 11 were in the East of England, died as a result of childbirth.

Stillbirths

A stillbirth occurs when, for whatever reason, a baby is born with no signs of life. In 2005 the stillbirth rate in England was 5.4 per 1,000 total births, and in Suffolk it was 2.7, meaning that 20 babies in the county were stillborn.

Infant mortality

Infant mortality is the number of babies born alive, who then die at less than one year of age. In Suffolk in 2005, 22 babies died under one year old, making the local infant mortality rate 2.9 per
1,000 live births, compared with the England rate of 5.0 deaths per 1,000 live births. The latest European rate was 5.2 per 1,000 live births, but this includes the former Russian and Eastern Bloc states. There are many reasons for infant deaths, which include congenital abnormalities and conditions occurring around the time of birth, and although the figure for Suffolk is relatively low, all the death rates for babies and young children need to be kept under careful review.

Perinatal mortality
Perinatal mortality rates are the number of stillbirths combined with the number of babies dying at less than 7 days of age, per 1,000 total births. In 2005 the rate in England was 8.0 and in Suffolk it was 4.9. However, even though the numbers are very small, perinatal deaths counted over a longer time period – 2003 to 2005 - show variability within Suffolk, from a rate of 3.8 in Forest Heath to 8.3 in St Edmundsbury (8.2 in England for the same period). Although Suffolk appears to fare relatively well compared with England, some of these deaths will be the result of potentially preventable conditions such as prematurity and low birth weight, and differences in rates across the county should be monitored.

Congenital abnormalities and morbidity
More babies are now surviving into childhood, for example those who are born very premature. For some babies that will be with various disabilities, and others will survive with birth defects that can now be corrected to some degree. In 2001 6,776 babies in England and Wales were born with some form of significant congenital anomaly (a rate of 114 per 10,000 live births).

Maternity services
The maternity services therefore have to be seen both as services for promoting and maintaining health, and also as acute and emergency services. Successful outcomes for mothers and babies rest primarily on good screening and risk detection, and secondarily on the actions taken and care provided. Whilst much care may be provided in the community, this has to be in the context of integrated service with excellent specialist obstetric and paediatric care immediately available and accessible.

Maternity care in Suffolk is provided mainly in the three district general hospitals and the community hospital unit at Eye, with referrals to the tertiary units at the Rosie Maternity Hospital, Norfolk and Norwich University Hospital or further afield as necessary for specialist care. Although most antenatal and postnatal care is provided in
the community, maternity care is co-ordinated from the hospitals, providing an integrated service from a multidisciplinary team of expert obstetricians, paediatricians, midwives, health visitors and general practitioners.

Women living in the east of the county have the choice of both lead professional and place of birth, with midwife led birthing units available for low risk mothers at the Gilchrist Unit at Eye and the ‘stand alongside’ birthing unit on Brook ward at Ipswich Hospital. Home births are also supported with a current home birth rate of 7.5%. In 2005 27% of mothers gave birth under the care of a midwife without involvement from a specialist obstetrician.

Patterns of maternity care have changed radically over the last 50 years, and are set to change again with the introduction in April this year of the Government’s paper ‘Maternity Matters’ (DH 2007). This document sets out a policy to promote choice for women about where each aspect of their care should take place, and if pregnancy is normal, whether their care should be led by a midwife or an obstetrician. Women should be able to consult a midwife as their first point of contact in maternity care, which is already the case for many women in Suffolk, and should be able to choose a home birth or birth in a midwife led unit if there are no adverse circumstances. Continuity of care from trusted health professionals is again a key element of government maternity policy.

In Suffolk in 2005, 90% of births took place in NHS hospitals, compared with 96.9% in England. The difference in Suffolk is the presence of a major maternity unit at USAF Lakenheath, and the fact that 5.7% of babies were born at home in Suffolk in 2005, which was the highest rate for the counties in the East of England, and more than double the rate of 2.5% for England as a whole. As the new Government policy is implemented however, many more women could choose home birth than at present, which would require a radical review of the resources and organisation of midwifery care. Safety in maternity care has to be of paramount importance, and ensuring that women have best professional advice and choice in planning their care is crucial.

Antenatal and newborn screening
Antenatal and newborn screening in the UK is also undergoing important changes, including the tests that are routinely available and the methods used. As well as screening the mother’s health, if parents choose, the fetus can be screened for blood group problems, structural fetal abnormalities (such as kidney defects), Down’s syndrome, neural tube defects, and can be screened for other abnormalities such as chromosome disorders if there are indications that this may be necessary. All newborn babies are examined from top to toe, including checks for congenital hearing problems and congenital dislocation of the hips, and all may have a blood spot screen for phenylketonuria, hypothyroidism, cystic fibrosis, sickle cell and thalassaemia. Newborn babies now have their hearing tested within the first days of life instead of having to wait until they are about eight months old, so that appropriate care can be started as soon as possible.
Breast feeding

Breast feeding is known to be beneficial for both mother and baby, and encouraging mothers to begin breast feeding and giving them support to continue are key aspects of maternity care. Unfortunately in Suffolk, only one of the District General Hospitals has a computerised maternity information system so we do not have robust information about the numbers of women in the county who breast feed their babies. Department of Health data for quarter 3 of 2006/07 shows that approximately 72.2% of women in Suffolk PCT and 64.7% of women in Great Yarmouth and Waveney PCT began breast feeding, compared with 68.5% in England and 69.6% in the East of England.

Smoking in pregnancy

Smoking in pregnancy is known to be associated with poor health for babies as well as their mothers, but pregnancy is a time when women may have the incentive they need to quit smoking. At present, we do not have good local data about the numbers of women smoking in pregnancy for the same reasons as the lack of breast feeding data, but we do know that approximately 15% of mothers in Suffolk PCT were still smoking at the time of delivery, something that the local ‘Stop Smoking Service’ is working hard to change. (Information for Great Yarmouth and Waveney PCT is not available).
4.2 Low birth weight babies

Low birthweight is a major health inequality and therefore Suffolk has a Local Area Agreement (LAA) to reduce low birth weight to 5.9% of all births by 2008. Low birthweight is defined as a weight at birth of less than 2,500 grams, and it may be the result of prematurity or of failure to grow at an appropriate rate in the womb. It is a concern because it is associated with developmental problems in childhood, and because it occurs more often to women who are disadvantaged in some way. Intrauterine growth restriction may be caused by fetal abnormality, or exposure to infection, or by illness in the mother. Both prematurity and intrauterine growth restriction

**References**

- Department of Health (2007) Breast feeding statistics Quarter 3 2006/07
- Department of Health (2007) Smoking at time of delivery statistics Quarter 3 2006/07
may be associated with poor nutrition, smoking and abuse of drugs or alcohol in the mother, and these are factors which women can be helped to address.

It can be seen from table 9 that Suffolk has a lower rate of low birthweight babies than England as a whole, and that there is not a great deal of difference between the Suffolk local authority areas. Problems of low birthweight are exacerbated for babies of very low birthweight (less than 1,500 grams), and in 2005 in Suffolk 76 babies were born weighing less than 1500 grams, representing 1% of the total live and still births. This compares with 1.5% in England and 1.2% in the Eastern Region for the same period. Even though rates in Suffolk are better than in England, many of these children will need extra care throughout childhood and some into adult life, so provision of services has to be considered as well as interventions to prevent low birthweight.

There are some causes of low birthweight which are not understood, and either not preventable or difficult to isolate and influence. However, there is significant evidence for the effectiveness of some interventions in reducing low birthweight, particularly:

- Smoking cessation interventions in pregnancy
- Smoking around pregnant women (second hand smoke)

We have therefore made a commitment through the LAA to:

- Support pregnant women to stop smoking
- Manage the data on smoking in pregnancy to inform service development
- Monitor the effectiveness of the service improvement
- Hold a low birthweight conference to raise awareness.

Table 9: Low birthweight babies: numbers and rates / County districts (CD) in Suffolk 2001-05

| County District | Live and stillborn infants with birthweight under 2500 grams | Total live and still births with a stated birthweight | 95% Confidence Interval |  |
|-----------------|-------------------------------------------------------------|------------------------------------------------------|-----------------------|
| Babergh          | 282                                                         | 4058                                                 | 6.9                   |
| Forest Heath     | 251                                                         | 3900                                                 | 6.4                   |
| Ipswich          | 525                                                         | 7510                                                 | 7.0                   |
| Mid Suffolk      | 273                                                         | 4413                                                 | 6.2                   |
| St Edmundsbury  | 383                                                         | 5622                                                 | 6.8                   |
| Suffolk Coastal  | 307                                                         | 4929                                                 | 6.2                   |
| Waveney          | 406                                                         | 5603                                                 | 7.2                   |
| Suffolk          | 2427                                                        | 36035                                                | 6.7                   |
| England and Wales| 200188                                                      | 2510838                                              | 8.0                   |

Source: NCHOD and ONS.

Low birthrate (LBWR): live and stillborn infants with birthweight under 2500 grams per 100 total live and still births with a stated birthweight. LBWRLL is the lower level of the confidence interval and LBRUL is the upper level of the confidence level.
Suffolk Stop Smoking Service, which is provided by the NHS, has employed a ‘smoking in pregnancy co-ordinator’ to advance these aims. Pregnant women are offered CO2 monitoring and midwives are encouraged to discuss smoking status and refer or offer support. Several health visitors and midwives are trained in Level 2 smoking cessation and are able to support families with babies and young children in reducing the effects of second hand smoke.

The low birth weight conference in Autumn 2007 will be a milestone in engaging multi-agency professionals to provide consistent, clear messages to families about smoking and the support available.

The Suffolk Smoke Free Alliance supported by local government and PCTs, is committed to enhancing and supporting the work in this field, to increase awareness of the dangers to children and pregnant women, of second hand smoke. Figure 5 shows percentage of women in Suffolk smoking at time of delivery from 2005/06 and 2006/07.

**Figure 5: Percentage of mothers smoking at the time of delivery – 2005/06 and 2006/07**

<table>
<thead>
<tr>
<th></th>
<th>No of Maternities</th>
<th>% Not smoking at time of delivery</th>
<th>% Not Known</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005/06</td>
<td>2006/07</td>
<td>2005/06</td>
</tr>
<tr>
<td>Suffolk PCT</td>
<td>6316</td>
<td>6428</td>
<td>82.5%</td>
</tr>
<tr>
<td>Great Yarmouth &amp; Waveney PCT</td>
<td>2129</td>
<td>2160</td>
<td>-</td>
</tr>
</tbody>
</table>

NB: Where more than 5% of data is missing it was not possible to report figures

Source: NHS Feedback Q4 2006/07 NHS Local Delivery Plan Healthcare Commission Indicator

### References

**Suffolk County Council (2006)**

The Children & Young People’s Plan 2006-09

**Suffolk County Council (April, 2007)**

Children and Young People’s Services Performance Handbook

### 4.3 Working in partnership for children and young people in Suffolk

**Why is working in partnership important for children and young people?**

Services for children and young people are delivered by a range of agencies. It is important that these agencies work together in a co-ordinated way to improve health and wellbeing of children and young people. The duty to co-operate is enshrined in the Children Act 2004.

Suffolk is moving towards a radically different way of planning and providing services for children through a Children’s Trust, which brings together all agencies responsible for children and young people.
What is Suffolk’s vision for children and young people?
The Children and Young People’s Plan (SCC 2006) is a statutory document setting the strategy for improving outcomes for children, based on the vision and key priorities agreed by Suffolk’s Children’s Trust Partnership, for the period 2006-2009. The plan was based on an extensive needs assessment and analysis of performance and service gaps (SCC 2007), and was informed by the views of children, young people, parents, carers, schools and a wide range of partners from across Suffolk.

The Trust’s vision is:

“To enable all children and young people in Suffolk to aspire to, and achieve their full potential, giving them the basis for a successful life as active members of their community.”

Through radical change and improvements in the way that services for children and young people are planned and delivered we will:

• Aim for every child and young person in Suffolk to achieve their aspirations, to be healthy and stay safe, to contribute successfully to their community and have a successful transition to adulthood

• Provide accessible, high quality integrated services with a particular focus on prevention and early intervention

• Give extra attention and support to vulnerable children and young people and those who have additional needs

• Involve children and young people, and parents and carers in the design and delivery of services

• Strive to achieve ever-higher standards and improved outcomes for all children and young people in Suffolk within available resources, by improving performance and efficiency, and

• Work across all organisations working with children and young people to develop a shared culture and values.

In 2004 the Government published ‘Every Child Matters: Change for Children, a new approach to the well-being of children and young people from birth to age 19’ (DH 2004). The Government’s aim is for every child, whatever their background or their circumstances, to have the support they need to:

• Be healthy
• Stay safe
• Enjoy and achieve
• Make a positive contribution
• Achieve economic well-being

Services for children and young people
A Children’s Trust Board member and a senior manager act as ‘champions’ for each of the five Every Child Matters themes. Each theme has identified priorities for improvement, supported by an action plan drawing together cross-partnership effort.

For the first theme, ‘Be healthy’, four priorities have been identified through a collaborative and evidence-based process, as a focus for improvement in Suffolk. These priorities are:

- Children and young people and their families and carers are supported and encouraged to adopt healthy lifestyles.
- Young people are well informed about sexual health and make informed choices.
- The emotional wellbeing of all children is developed and their mental health needs appropriately addressed.
- Children and young people can access information, advice and support for issues concerning substance misuse.

Following the completion of the first year of the Plan, a Review (SCC 2007) has been conducted which has revisited the needs analysis, reviewed progress against action plans and targets, and sought feedback from children and young people on the selection of priorities.

The Suffolk Children’s Trust Partnership has confirmed that the four priorities for ‘Be healthy’ will remain the same for 2007-2008 with particular focus on:

- Reducing childhood obesity
- Reducing teenage conceptions

In terms of service delivery, the development of Children’s Centres across the county is providing an essential hub for the delivery of integrated services to young children and their families. Fourteen of 35 planned centres have opened so far, with the remainder due to be open by 2008. Those centres serving the most deprived areas (13% of Suffolk) are providing a wide range of support, including childcare integrated with early education, child and family health services, parenting education and family support services, support for children with additional needs and their families, a base for a childminder network, and support into employment and training, linking with Jobcentre Plus.

What other partnerships support the health and wellbeing of children and young people in Suffolk?

In addition to the Children’s Trust, the PCT works through joint arrangements with the Suffolk Strategic Partnership (SSP) and the Local Strategic Partnerships (LSPs). Local partnerships bring together a wide range of agencies from the public sector including local authorities, the NHS and police together with private businesses, community and voluntary sectors. This enables services to support each other in initiatives for the benefit of the local community. There are currently six LSPs in Suffolk - Western Suffolk, East Babergh, Suffolk Coastal, Ipswich, Mid Suffolk and Waveney.

Suffolk Local Area Agreement (LAA) is an integral part of Suffolk’s approach to improving...
outcomes for children and young people. The LAA aims to work across organisational boundaries using new, flexible and effective arrangements to achieve a series of outcomes for children and young people. The Children’s Trust Partnership acts as the Block Board for the fourteen LAA targets for children and young people, to be achieved by March 2008. These LAA targets are incorporated into the Children and Young People’s Plan. Examples include better educational attainment for Looked After Children, preventing and reducing obesity, and reducing the number of low birthweight babies.

References
Suffolk County Council (June 2007). Review of the Suffolk Children and Young People’s Plan

Case study: School-based health services – an example of partnership working

School-based health services are a confidential drop-in facility for high school pupils in year 9 and above and offer information, advice and support on a range of health related issues. The sessions usually take place during a lunchtime on the school site and are staffed by a youth worker and/or nurse so as to give the facility of group discussion alongside one to one confidential sessions for young people with a specific issue to discuss. The service is holistic in approach but ensures that young people can access advice on sexual health, contraception and pregnancy and make informed choices about any of the risk taking behaviours they may be contemplating. School-based services are also committed to improving support to help young people to stop smoking.

Currently 10 high schools in Suffolk offer a school-based health service, all of which function as a partnership between the PCT, Suffolk Youth and Connexions Service or voluntary youth work organisations and the school. The services are planned in consultation with school communities and are key to reducing health inequalities in Suffolk. The services are confidential but raise awareness of lifestyle issues and the importance of creating safe environments in schools by closely linking with the PSHE (Personal, Social & Health Education) co-ordinators.
4.4
Use of hospital services by children in Suffolk with a focus on injuries

Why do we need to understand how hospital services are used by children?
Health of children is one of the key indicators of the health status of any society. The pattern of utilisation of hospital services by children is of interest to professionals, public and policy makers as it indicates the true health status of this vulnerable group of our population.

- Children and young people are frequent users of all types of healthcare compared with adults
- Although the majority of childhood illness is managed within the home or in primary care, each year in the East of England just under 1 in 10 children are admitted to hospital
- Every admission is a great cause of concern to the child’s family and is a potentially daunting experience for the child
- These admissions also represent significant cost to the local health system

This chapter provides a brief overview of the pattern of hospital use by children in Suffolk with a particular emphasis on injuries.
What do we know about use of hospital services by children in Suffolk?

The main source of the data on hospital admissions generally is Hospital Episode Statistics (HES), which tell us about all hospital admissions and day cases.

Data for three years from April 2002 to March 2005 for children aged under 19 are shown by Local Authority area. In the three years there were 7,957 elective admissions and 30,360 emergency admissions in Suffolk. Figure 6 shows the directly age standardised rates for both categories with East of England rates for comparison. There is considerable variation in emergency admissions, and the highest rate is seen in Ipswich and St Edmundsbury which are also the sites of the main hospitals in Suffolk. This suggests that proximity to a hospital increases attendance. The vertical bars show the confidence interval of the rates.

Other analyses for the East of England have shown that there is a clear correlation or association at local authority level between the number of emergency admissions and the deprivation level in the community.

What are unintentional injuries and why are they an important public health issue?

Unintentional injury can be defined as “injury occurring as a result of an unplanned and unexpected event which occurs at a specific time from an external cause”. The types of injuries are; transport (rail, road, air, water), poisoning, falls, fire, flame and smoke, natural and environmental factors, submersion, suffocation and foreign bodies.

Unintentional injury in children is a major cause of ill health and disability in the UK. There are variations in the occurrence of these injuries by age group, sex, socioeconomic group and place where they reside. Preschool children are more likely to be injured in their homes than school children who are more likely to be injured on the roads. Boys experience more injuries than girls.

How many serious accidents do children suffer?

All children have accidents, but parents and society have to be constantly vigilant to ensure that children do not come to avoidable serious harm, to reduce risks as far as possible, and to see that the right

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1Directly Standardised Rates (DSR) - The directly age standardised rate (DSR) is the rate that would occur in a given standard population if it experienced the same age specific rates as the population of interest. In this report, the standard population that has been used for comparison with local populations, is either the European Standard Population, or Suffolk as a whole. This allows us to look at admission rates, death rates or rates for any other event, for specific age groups in the population and compare them with other areas.
treatment is readily available for a child if they need it. Figure 7 shows the patterns of attendance at hospital accident and emergency departments in Suffolk for children and young people in the years 2003/04 to 2004/05, which could be expected to be relatively serious.

The attendance rate for boys exceeds that for girls in every age group and in each locality, but there are marked differences between the age groups and localities. The most urban areas appear to have the most A&E attendances, again suggesting that proximity to a hospital increases attendance, which has been found in adult attendance rates. It is also of note that it is the youngest and the oldest age groups who have the highest attendance rates. These figures do not tell us about the nature or severity of the accidents, or what happened to the child next. Further work is needed to gain a better understanding of these figures to inform accident prevention and to ensure that the most appropriate care is provided as near the injured child as possible.

What types of injuries cause children to be admitted to hospital in Suffolk and does it vary across the PCT area?

Road traffic accidents are an important cause of hospital admissions not only in Suffolk but across the East of England. Table 10 shows data for road traffic accidents by local authority and age groups compared to the East of England data. Suffolk is making progress with its local targets to reduce the numbers of children and young people killed or seriously injured on the roads, and its School Travel Plans aim to encourage road safety.

Data for non traffic injury admissions for all local authorities in East of England is shown in figure 8. Of the seven local authorities in Suffolk, the rates are higher for Suffolk.
Table 10: Road traffic accidents (RTAs) due to motor vehicles by local authorities in Suffolk

<table>
<thead>
<tr>
<th>Age group</th>
<th>Local authority</th>
<th>Occurrence of RTA</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-14</td>
<td>Ipswich</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>Forest Heath</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>St Edmundsbury</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>Mid Suffolk</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>Suffolk Coastal</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>Babergh</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>Waveney</td>
<td>Average</td>
</tr>
<tr>
<td>15-24</td>
<td>Ipswich</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>Forest Heath</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>St Edmundsbury</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Mid Suffolk</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Suffolk Coastal</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>Babergh</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>Waveney</td>
<td>Average</td>
</tr>
</tbody>
</table>

Source: Hospital Episode Statistics and ONS Mid-year estimates for populations (provided by ERPHO)

Coastal and Babergh, and significantly lower for Forest Heath. In the funnel plot (figure 8) the values for these local authorities lie outside the base of the funnel.

This shows that the higher than average rates observed by these authorities are real and not due to chance variation.

Reference

4.5 Services for ‘Looked After Children’

The term ‘Looked After Children’ (LAC) is used to describe the group of children of all ages who, for a wide variety of reasons, have been placed in the care of local authorities. In Suffolk there were 705 children living in care on 31 March 2007. This number has been relatively stable over the last 5 years. ‘Looked After Children’ are amongst the most socially excluded of all children and a series of Government reports show that they have significant physical, environmental and mental health needs.

In Suffolk, as in the rest of the UK, approximately 75% of children entering care do so because of child abuse and neglect. The remainder enter care because they may have very specialist needs as disabled children or because of other factors such as the breakdown of relationships within families as behaviour becomes more challenging in adolescence. 60% of children in care are boys and 40% are girls. Of these:

- 25% are under 1,
- 20% between 1 and 4
- 12% between 5 and 9
- 37% between 10 and 15
- 6% who are 16 to 18 years old.

The vast majority of the 45% of children in care under the age of 4 are on Care Orders and will leave care through adoption within two years. Approximately 250 children and young people enter care each year with a similar number leaving. In recent years the number of children entering care has reduced but older children are remaining in care longer.

The greatest number of children in care come from the Ipswich Borough Council area (275 or 39% of the county total of 705), an equivalent rate of 102 per 10,000 of Ipswich’s 0-17 population. The second largest area is Lowestoft followed by areas of deprivation such as Haverhill, Mildenhall and Stowmarket.

Approximately 85% of children in care in Suffolk live with foster families. There are five children’s homes providing 32 places. Some of the children’s homes have specialist roles, for example, to assess children, or for younger children who have not been able to sustain an adoptive or long term foster placement because of their needs. Most children in voluntary care leave care at 16 years though the combined agencies continue to provide them with support into and beyond their maturity.
The role of the health service
Suffolk PCT has its own ‘Looked After Children’ Team whose aim is to improve health outcomes for children and help them to gain maximum life chances. The LAC team is made up of a Designated Specialist Doctor, a Designated Senior Nurse and three Nurse Specialists. ‘Looked After Children’ are referred to the team from a range of sources and undergo a carefully co-ordinated assessment and follow-up process.

In recent years the team have led a process of change which sees assessment of children’s health needs go beyond traditional clinical approaches. The team now looks at the whole environment and life experience of the child, assessing the health impact and looking at ways in which changes can be made to improve life chances. Each child has a Health Care Plan which is regularly reviewed, and includes plans of the dentist, GP, school nurse and health visitor. The ‘Looked After Children’ Health Team is managed by the Designated Nurse for Safeguarding Children within Suffolk PCT.

The role of Children and Young People’s Services
The role of Children and Young People’s Services in relation to ‘Looked After Children’ is to provide professional leadership. The service co-ordinates plans to achieve permanence for the child either through re-unification with the birth family, or through placement with an alternative family, or through adoption, or permanent fostering.

Every ‘Looked After Child’ has an allocated social worker who is responsible for co-ordinating the child’s plan to meet their health, education and social needs, and to ensure that they have appropriate contact with members of their birth family.

The allocated social worker is responsible for ensuring that carers have information about the child’s background and needs, and that consent to act on behalf of the child has been obtained.

Plans for ‘Looked After Children’ are reviewed on a regular basis as a statutory requirement.

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4.6 Children who are homeless

What is the issue?
Homelessness can affect all ages, but the results for children’s development, particularly education and health, are profound and life altering. Thankfully the numbers without a roof over their heads are small, but the issue extends to all young people without a permanent, stable address, of a recognised standard, whatever the cause.

Why is it a problem?
Research shows that homeless families living in temporary accommodation, frequently bed and breakfast (B&B), report higher rates of accidents and infection and have more mental health problems. The same households are also less likely to be registered with a GP, and the single homeless particularly may be higher users of A&E services rather than making appropriate use of other primary care services, including General Practice. In addition, both alcohol and drug problems are a recognised and greater problem amongst homeless people, with research suggesting the young homeless in particular use drugs in order to help cope with the trauma associated with homelessness.

What causes the problem?
Homelessness, and particularly its effect on children and young people, is a complex problem dependent on a number of factors including housing availability, poverty and other markers of social deprivation, as well as individual problems such as debt, and poor mental or physical health. These can be both a cause of and a consequence of poor housing and homelessness. In addition, relationship breakdown of either parents, carers or with developing teenagers is a frequent precipitating factor. The risk of homelessness varies between groups in our society in other ways, and it is known that ethnic minority households are around three times more likely to become statutorily homeless. Research suggests that a complex cycle of deprivation and social isolation interact, with poor language and work skills contributing to the disadvantage.

What is the extent of the problem in Suffolk?
Homeless households in Suffolk are lower as a proportion than the England average of 7.8%, with 6.7% (1,133 households) on local authority housing registers who are statutorily homeless (defined as a household deemed to be unintentionally homeless, and considered to be in priority need, such as families with dependent children). However, this...
masks considerable variation between Local Authorities in Suffolk, with generally worse rates as well as actual numbers in urban areas. Ipswich is significantly worse at 9.3% (comprising 331 homeless households) compared to the England average of 7.8% on the housing register. It is estimated that 62% of these homeless households include dependent children or an expectant mother.

What these figures do not count are the unknown numbers of young people in their teens and beyond who are sleeping rough or ‘sofa surfing’ with friends, often following parental relationship breakdown. These young people are frequently unknown to, or unable to access, appropriate services, just when they most need them for social, educational or health purposes at a time of chaotic or risk taking behaviour.

**What are we doing/planning to do in Suffolk?**

Recent emphasis has been on tackling the underlying causes of homelessness and prevention, as well as addressing the health needs of homeless people. Ensuring children and young people live in decent houses, free from the effects of poverty, is a specific commitment within the ‘Achieving Economic Well-Being’ target of Every Child Matters (DH 2004), and signed up to by the partners working across Suffolk, including Local Authorities and the NHS through the PCT. Significant progress has been made over the past year in increasing the proportion of social housing meeting the decent homes standard; reducing the number of young people (16 to 17 year olds) in B&B accommodation; and encouraging take up of benefits by disadvantaged families. This will have ‘knock on’ benefits in all the target areas, but particularly for the ‘Be Healthy’ initiatives for the Children’s Trust.

Other initiatives aim to buy time and encourage a safe refuge, such as following a family argument, with ‘Nightstop’ schemes run by the YMCA which provide 16 to 17 year olds with a roof over their heads with a host family.

In terms of health and homelessness specifically, five key areas have been identified with the ability to achieve positive shared outcomes, and these have been adopted by the Local Homelessness Strategy for 2003-2008. This is a partnership strategy co-ordinated by Ipswich Borough Council (IBC) on behalf of all relevant statutory and non-statutory agencies – this includes all local councils, and PCTs through community health services and specific health initiatives such as the Health Outreach Project (HOP) which provides a homeless outreach team, and a health visitor for the homeless.

The five key areas identified for action are:

- Improving health care for families in temporary accommodation
- Improving access to primary care for homeless people
- Improving substance misuse treatment for homeless people
- Improving mental health treatment for homeless people
- Preventing homelessness through appropriate, targeted health support.
The Yard Project, Lowestoft

Several community consultations undertaken in Lowestoft’s most disadvantaged communities have revealed the concerns of residents about low-level antisocial behaviour alongside the recognition that their young people had little opportunity for local training, employment and community involvement. In September 2005 local residents and youth workers came together to form ‘The Yard Project’ in one of the towns’ most deprived wards. This project has since developed into a ‘community hub’ following the conversion of a derelict commercial property which now operates as a community youth engagement initiative. Young people entering the project live locally and include those leaving care and supported housing who have experienced challenges in education, training, employment, homelessness, or all of these.

On a day-to-day basis ‘The Yard Project’ provides learning and training opportunities for young people under a much wider programme of experiential learning in preparing for work. Young people, with the support of Youth Workers, can develop life skills and shape reliable and responsible work habits in addition to gaining practical skills which can lead them into employment or further work through The Yard’s Community Interest Company.

Young people have taken a leading role in a community initiative known as ‘Pride in Our Road’, which aims to discourage vandalism and invest pride in streets and gardens of the super output areas served by Lowestoft Together Neighbourhood Management programme. With support from The Yard, young people are rebuilding walls, tending front gardens and creating planters for local residents.

More recently The Yard Project has been awarded funding by the ‘Lowestoft Together Board’ to actively engage young people in a scoping exercise to inform the delivery of youth provision - 600 young people expressed a willingness to contribute to making their community a better place, to make themselves part of finding local solutions to their challenges and in nurturing hope.

References


4.7 The future of health visiting and school nursing in Suffolk

We know that an individual’s experience before birth and in early life has a crucial impact on their life chances through childhood and into adult life. Improving the health and welfare of parents and their children is in the long term the surest way to a healthier nation. Health visitors and school nurses are well placed as key public health clinicians to support national and local initiatives to deliver health improvement and to tackle health inequalities.
What is the problem?
The development of health visiting and school nursing to deliver their roles as key public health clinicians has been constrained for several years by a cycle of management structure re-organisation. This has resulted in many practitioners resorting to reactive task orientated working rather than a more proactive approach as family centred public health professionals. Until recently health visitors have been attached to general practices focusing solely on children under 5. School nurses are on average each responsible for approximately 4,000 school age children.

Over the last few years there has been a change in the way we expect to access our health services. Accessibility to advice and support for parents has increased with excellent internet sites and many commercial activities aimed at parents with babies and very young children. Older children and young people also have access to a huge range of technology on a daily basis. It seems that health visiting and school nursing has not yet fully adapted to these changes.

How do we intend to develop the role of health visitors and school nurses?
Research has shown that in order to break the cycle of poor parenting, intervention needs to begin before the 28th week of pregnancy. ‘Reaching out’, an action plan for social exclusion (DH, 2007), has led to the introduction of a major national pilot for health visitors and midwives. Based on a 30-year longitudinal study from America, Family Health Nurses provide an intensive programme of home visiting from pre-birth to two years. If successful, this will have a major impact on workforce planning and development for the future. Developments are needed to the health visiting services if we are really to make a difference to the lives of families with young children through tackling poverty and social exclusion.

Suffolk PCT is committed to changing and developing the role of health visitors and school nurses to enable them to deliver the challenging public health agenda. We will develop and commission a model of service that enables health visitors and school nurses to focus their skills and expertise on the areas where they will have the greatest impact on tackling health inequalities and preventing social exclusion in children and families. The service model will include integrated children’s teams organised in community clusters, which will enable practitioners to work across organisational boundaries. The service will deliver evidence-based programmes at local level with measurable outcomes.
Health visitors will lead a team to deliver a progressive, universal model of child health promotion that is systematically planned and delivered to give a continuum of support according to need at neighbourhood and individual level, in order to achieve greater equity of outcomes for all children. Those with greatest risks and needs will receive more support.

School nurses are a key link between health and education and will be able to contribute fully to multi-agency programmes to enable children and young people to reach their full potential. Choosing Health (DH, 2004), the government’s vision for improving health in the population, recognises that new approaches are required to enable individuals to become more actively engaged in improving their health.

School nurses will work much more closely with education and other partners. Examples will include supporting the Suffolk Healthy Schools Programme, developing initiatives for Personal, Social & Health Education (PSHE) and maximising opportunities to promote health in ‘Extended schools’. Some innovative practices are already evolving locally in school nursing e.g. Chlamydia screening in sixth forms.

In the future, we will need to work with young people to develop new ways of communicating with them e.g. through text messaging and more creative use of the internet in order to support them in making lifestyle changes.

A new Baby Café has recently opened in Felixstowe Library. This service has been developed by the health visiting team in conjunction with the county council. It is a drop-in service to support pregnant women who are interested in breastfeeding and mums who are currently breastfeeding. The café provides a relaxed atmosphere for parents and their children to socialise and to access the library’s resources, such as Bookstart.

Health visitors, school nurses and police officers have recently started working in the same building in Gainsborough clinic in Ipswich. This provides an innovative way of different professionals working together in the community.

References


5

Health improvement initiatives for children

5.1 Healthy schools

5.2 Childhood obesity

5.3 School meals

5.4 Sexual health
   - Teenage pregnancy
   - Sexually transmitted diseases
   - Action to improve sexual health

5.5 Alcohol use in young people
5.1 Healthy schools

All schools in Suffolk are engaged in activities that will help children to be happier, healthier and better able to learn.

There is a coordinated approach to help schools make further progress through the National Healthy Schools Programme, which aims:

- To support children and young people in developing healthy behaviours
- To help to raise pupil achievement
- To help to reduce health inequalities
- To help promote social inclusion.

The Suffolk Healthy Schools Programme is the local education and health partnership responsible for supporting schools and developing partnerships in this area of work. Currently, there are around three hundred schools formally signed up to the Programme and it is anticipated that the remaining sixty schools will do so during the coming year. The government has set a target for 75% of schools to achieve National Healthy School Status (NHSS) by December 2009.

In order to achieve NHSS, schools have to meet a range of criteria in four key themes:
- Personal, social and health education (PSHE) including sex and relationship education and drug education
- Healthy eating
- Physical activity
- Emotional health and wellbeing (including bullying).

The four themes have to be addressed through a whole school approach encompassing the following aspects:
- Leadership, management and managing change
- Policy development
- Curriculum planning and resourcing including work with external agencies
- Teaching and learning
- School culture and environment
- Giving pupils a voice
- Provision of pupils’ support services
- Staff professional development needs, health and welfare
- Partnerships with parents/carers and local communities
- Assessing, recording and reporting pupils’ achievement.
Many schools realise the importance of prioritising this area of work. It is increasingly being seen as a whole school improvement tool rather than ‘just another initiative’. It also plays a major role in helping schools address the five ‘Every Child Matters’ outcomes (DH, 2004). The training and support given to schools provides them with a framework for tackling the health agenda in a more coordinated and comprehensive way. It also helps them to see their contribution to major public health issues such as reducing teenage pregnancy and childhood obesity.

A school working towards the physical activity theme, for example, is expected to have a comprehensive physical activity policy. They will be striving to deliver a high quality PE curriculum. In addition, they will be offering a good range of extra-curricular activities catering for the needs of all pupils. There will be opportunities for both competitive sport and broader physical activity. Each day might begin with a short burst of physical activity involving pupils, staff and parents. There could also be trained play leaders, both adults and children, encouraging structured activities at playtimes and lunchtime. The school will be promoting more environmentally friendly, active ways of travelling to and from school through the School Travel Plan.

It is important that ‘Healthy Schools’ maintains its high profile locally and nationally. At present, we do not have an accurate picture of how schools are trying to improve health, even for some important areas such as the content of PSHE.

Although local participation in the project is high, there is currently slow progress in Suffolk schools achieving NHSS. There is no doubt that the multitude of demands placed upon schools will make it difficult for some to achieve NHSS in the short term. The specific challenges faced will differ between, for example, a large high school in an urban area and a small rural primary school. Yet, NHSS should only be regarded as a milestone upon a continuous journey of health improvement. The real challenge will be to ensure that, not only do schools maintain the standards met under NHSS, but go on to develop further. At that point, they will begin to make a significant contribution to the public health agenda.

Table 11: Suffolk Healthy Schools Programme Participation figures

<table>
<thead>
<tr>
<th>Year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>8%</td>
<td>14%</td>
<td>19%</td>
<td>22%</td>
<td>22%</td>
<td>31%</td>
<td>57%</td>
<td>71%</td>
<td>83%</td>
</tr>
</tbody>
</table>

* A further 6% of schools have applied to join the Programme in autumn 2007

References

Department of Health (2004)
Every Child Matters. London, DH
5.2 Childhood obesity

Current trends in obesity may mean that today’s children have a shorter life expectancy than their parents. It is estimated that without effective action one fifth of children aged 2-10 years will be overweight or obese by 2010.

The rapid increase in levels of overweight and obesity in both adults and children has occurred in a time scale too small for genetic changes to be the cause. This means that growing health problems are likely to be caused by behavioural and environmental changes in society. It is also a major health inequality issue.

The terms overweight and obese are used to describe increasing degrees of excess body fat, which can lead to adverse effects on health and wellbeing. Some problems occur in childhood whilst others appear in early adulthood as a consequence of childhood obesity.

The most important long-term consequence of childhood obesity is its persistence into adulthood and the early appearance of diseases normally associated with middle age, such as ‘mature-onset’ or type 2 diabetes and high blood pressure. Other possible consequences for children and young people include mechanical problems such as back pain and foot strain and worsening of asthma.

Prevention and treatment of obesity is a key target for the Children’s Trust in Suffolk, but until now we have not had good data about the local situation. In the academic year 2005/06 the first national screening took place for children in the reception year and those in year 6. Over 9,000 children in Suffolk had their height and weight measured (approximately...
97% of the eligible children in reception year in the former East and West Suffolk PCT areas and 57% in Waveney PCT, and 77% and 74% of year 6 children), and the children’s body mass index (BMI) were calculated. It was found that in the reception year 7.9% of girls and 8.9% of boys were obese, and in year 6, 17% of girls and 19% of boys. This compares with 9.4% of reception year children and 16.3% of year 6 children in the East of England as a whole (although these figures are based on only 44% of eligible children across the region). The Suffolk data showed no significant differences between children in different areas of the county, and there does not appear to be a link with deprivation (ERPHO 2007).

The survey will be repeated nationally every year for children in those year groups. This will provide us with evidence of the impact over a period of time of sustained actions to encourage healthier lifestyles for Suffolk children.

A life course approach to preventing childhood obesity

The results of this survey suggest that measures to prevent the increase in childhood obesity need to be targeted across the whole population (ERPHO 2007). As overweight and obesity are largely preventable and have serious consequences, supportive actions need to start from birth and follow the child through his or her lifetime. The ‘Fit for the Future Group’, affiliated to Suffolk Strategic Partnership co-ordinates this work in Suffolk and has a very comprehensive membership. This partnership working enables comprehensive, innovative actions to be taken as shown in table 12.

Table 12: A life course approach to preventing childhood obesity

<table>
<thead>
<tr>
<th>Period</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal period</td>
<td>Breastfeeding promotion, healthy eating advice for pregnancy and breastfeeding support training for staff</td>
</tr>
<tr>
<td>Postnatal period</td>
<td>Breastfeeding support including peer group support and promotion of breastfeeding in public places, weaning advice, cookery and infant feeding advice</td>
</tr>
<tr>
<td>Pre-school period</td>
<td>Support for active play and physical activity with improvement of outdoor play areas and Children’s Centres as the focus for healthy eating advice reinforced by health visiting team contact (Child Health Promotion Programme CHPP)</td>
</tr>
<tr>
<td>Schools</td>
<td>Development of Healthy Schools Standards to include a schools’ food policy, nutritional information, physical activity promotion and development of curricular material and teacher training</td>
</tr>
<tr>
<td>Extra-curricular</td>
<td>Promoting safe walking to school, encourage cycling, promote lunch time and after school activities. Extended schools – cookery clubs etc</td>
</tr>
<tr>
<td>promotion of physical activity &amp; healthy eating</td>
<td></td>
</tr>
</tbody>
</table>

Source: Commissioning Obesity Services (NHS Modernisation Agency, 2005) Adapted
Health improvement initiatives for children and young people

5 a day' consumption of fruit and vegetables
At present we do not have good local information about adults’ or children’s diets in Suffolk, and although there is now good information about the extent to which adults in Suffolk engage in sport, there is no equivalent information for children and young people. We do have ‘synthetic’ ward estimates of the numbers of children and young people in Suffolk who consume the recommended 5 portions of fruit and vegetables a day (‘5 a day’). These are based at ward level and derived from the Health Survey for England. This shows that an average of 36.7% of the children in Suffolk have ‘5 a day’, but the figures suggest considerable variation across the county, with estimates of between 25.3% of children in Whitton ward (Ipswich) and 47.6% of children in Eastgate ward (Bury St Edmunds). Although these figures are only estimates, they show that the lowest consumption of fruit and vegetables amongst children is in the most deprived electoral wards and less than half the children across Suffolk are eating the recommended amounts. This is an area of concern for parents and all health, education and social care agencies across the county, especially as this is a county where much of the country’s fruit and vegetables are grown.

Physical activity
MEND (Mind, Exercise, Nutrition, Do It…. ) is a nine week, eighteen session family based treatment intervention for obesity which was developed by the Institute of Child Health and Great Ormond Street. Suffolk now has courses at four sites – Waveney, Bury St Edmunds, Stowmarket and Ipswich with further sites planned in Felixstowe and Sudbury. The course has been greatly valued by those families who have participated. However, recruitment to the programme has been slow despite a high level of publicity. This reflects the sensitivity and difficulty in targeting initiatives designed to help children who have already become obese.
School meals

As caterers to 97% of schools within the county, Suffolk County Catering (SCC) provide recipes and menus to schools, enabling nutritious, traditionally prepared meals to be prepared by their kitchen teams. Primary and Middle school menus are nutritionally analysed by SCC via a specialist database and verified by a senior nutritionist from Ipswich hospital.

The menus meet all recent Food Based Standards and are moving close to meeting the nutritional standards due to be introduced in September 2008. Suffolk County Council are aware that changing children’s eating habits will take time and it is important not to alienate schools and pupils by moving too quickly. A school meals survey involving over 6,500 responses from parents was completed in January 2007.

References


Holly’s mother had been asking for help from the NHS and her school for 7 years to help address her weight problems which were causing her to be bullied at school. Holly (11) took part in the MEND programme and lost more than 2 stone in a year. ‘She has so much more energy now; she is so much more bubbly and happier in herself. I’m really proud of her.’

Amanda (11) has become a totally different child – not only has she lost two stone in weight but her confidence has gone through the roof. She now plays football all over East Anglia and is always out making new friends. As well as taking part in regular physical activity, Amanda checks what she eats and likes to help her mother cook some of the healthy recipes they learnt together on the MEND programme.

James (12) ‘I can now get into jeans and enjoy shopping for trendy clothes, I have learnt new healthy recipes and enjoy cooking with my mum.’

If you’d like more information on the content of the MEND programmes, where the local ones are running currently or how to join, please contact: Linda Paterson - MEND programme Co-ordinator 01473 770007 linda.paterson@suffolkpct.nhs.uk

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Holly’s mother had been asking for help from the NHS and her school for 7 years to help address her weight problems which were causing her to be bullied at school. Holly (11) took part in the MEND programme and lost more than 2 stone in a year. ‘She has so much more energy now; she is so much more bubbly and happier in herself. I’m really proud of her.’

Amanda (11) has become a totally different child – not only has she lost two stone in weight but her confidence has gone through the roof. She now plays football all over East Anglia and is always out making new friends. As well as taking part in regular physical activity, Amanda checks what she eats and likes to help her mother cook some of the healthy recipes they learnt together on the MEND programme.

James (12) ‘I can now get into jeans and enjoy shopping for trendy clothes, I have learnt new healthy recipes and enjoy cooking with my mum.’

If you’d like more information on the content of the MEND programmes, where the local ones are running currently or how to join, please contact: Linda Paterson - MEND programme Co-ordinator 01473 770007 linda.paterson@suffolkpct.nhs.uk
helping the organisation develop their service for the future.

Staff training and development has continued throughout the year, with additional sessions helping kitchen teams understand and deliver the new Food Standards. Suffolk County Council work closely with the Suffolk Healthy Schools Programme, sharing training sessions for teachers, and helping them attain and compile their Whole School Food policy, and work towards attaining Healthy Schools Status. Suffolk County Council are also represented on the Fit for the Future Group, a multi disciplinary task group working together, with the shared aim of improving the health of all those who live and work in Suffolk (see 5.2 above). The group are currently promoting the MEND scheme (see 5.2 above) supporting parents and children tackle obesity.

Within schools SCC is again running the successful Kitchen Garden Project, issuing free seeds to 180 schools, allowing produce to be grown and eaten by pupils in class or as part of their school lunch. In addition to this 10,000 seed packs have been issued to students via schools, allowing them to grow the produce, at home with their parents or carers.

5.4 Sexual health

Why is sexual health a problem in young people?

Britain has seen an increase in sexually transmitted infections (STIs) since the 1990s and the United Kingdom continues to have the highest teenage pregnancy rate in Western Europe.

The need to decrease teenage pregnancy is important as the young teenage mother is more likely to present to medical services late, has a greater chance of pre-term labour and a low birthweight baby and increased risk for the child of hospital admission during the first 5 years of life. Although a slow but steady decrease in the teenage pregnancy rate in England has occurred between 1998 and 2004, in 2005 46.9% of pregnancies in those under 18 years ended in legal termination and therefore continued efforts to prevent those pregnancies in the first place should continue.

Decreases in the rates of STIs were seen in England through the 1960s until the 1990s, but more recently there has been a year on year increase. Sexually transmitted infections can be caught through unprotected vaginal, oral or anal sexual intercourse and genital contact with infected partners. The commonest infection is Chlamydia. Two thirds of
recorded Chlamydia infections are in those aged under 25 years of age, and around 1 in 10 sexually active men and women between the ages of 16 and 25 are infected with Chlamydia – often without knowing. The infection is easily cured with antibiotics but if the infection is unrecognised and therefore not treated, Chlamydia can cause pelvic inflammatory disease in between 10% and 30% of infected women, which can lead to ectopic pregnancy and infertility.

Changes in the social lives of young people also have an effect and there is increasing evidence that alcohol and drugs are used to enhance sexual activity (DH, 2007) This leads to high risk behaviour, increasing the risk related to both STIs and pregnancy.

Teenage pregnancy in Suffolk
The teenage pregnancy rate in Suffolk is significantly lower than the national average as can been seen in Figure 9. Within Suffolk most districts also have lower rates, however Waveney has similar rates to the national average and in Ipswich teenage pregnancy rates 2002-04 were significantly higher than the national average.

The map in Figure 10 shows the 14 wards within Suffolk that have significantly higher teenage pregnancy rates than the Suffolk average. The highest concentration of these wards is in the Ipswich area, followed by Waveney – which has historically been the case – and these should continue to be high priority areas on which to focus action. However the Mid Suffolk

Figure 9: Teenage conception rates Females aged under 18 years Residents of county districts in Suffolk 1998-2004

Source: NHS Information Centre, and Compendium of Clinical and Health Indicators 2006
wards of Central Stowmarket and Haughley & Wetherden have emerged during 2002-04 as new areas of concern.

Pregnancies in girls under 16 years of age are particularly worrying. An average of 80 such pregnancies occur in Suffolk each year and figure 11 shows that although the Suffolk rate is significantly below that of England, the pattern between districts is similar to figure 9 - rates of pregnancy in girls under 16 living in Ipswich are significantly higher than those in Suffolk Coastal, Mid Suffolk and Babergh districts.

Many, but not all, teenage pregnancies are unintended. Although difficult to assess, the majority of pregnancies ending in legal termination (TOP) are not intended. Nationally, only 1% of TOPs are carried out for suspected fetal abnormality. In 2005 17.2% of pregnancies among women of all ages living in Suffolk resulted in legal termination compared to 43.6% of pregnancies in those under 18 years of age. Reducing the teenage conception rate is a Local Area Agreement target and a priority for Suffolk County Council.
Sexually transmitted diseases in Suffolk
A high proportion of all those diagnosed with STIs in local Genito-Urinary Medicine (GUM) clinics are under the age of 25 as can be seen in Figure 12. Over 60% of those with Gonorrhoea or Chlamydia are aged 16-25.

The number of people under the age of 19 diagnosed with sexually transmitted infections in local clinics has increased since 2000 as seen in Figure 12. The 2006 figures show a decrease and this could be due to various factors. Possibly it represents a true decrease in the number of those with STIs but this is unlikely as the recently started Chlamydia screening programme has identified Chlamydia infection in 11% of those screened under the age of 19. This confirms that there are more people with STIs undiagnosed within the community than those attending clinics for diagnosis and treatment.

What are we doing about improving sexual health in Suffolk?
The Suffolk Teenage Pregnancy Team, Community Reproductive Health Services, Sexual Health Clinics, the PCTs, County Council and partners in Local Strategic Partnerships have worked together to improve services available to young people. Currently outreach services specifically for young people offering advice and methods of contraception are available at a wide range of community venues and schools. Suffolk PCT is consulting on a specification for an integrated sexual health service for residents which will enable a wider range of sexual health services to be offered at these venues.

In June of 2006 Suffolk PCT started a Chlamydia Screening service for those aged 16-24 and it is now screening almost 200 people each month, aiming to increase this to 1,000 people a month when fully operational. From June 2006 until the end of March 2007 11% of the 1,279 young people under 19 who were screened were...
found to have a Chlamydia infection and treated. A similar service is available to Waveney residents led by Great Yarmouth and Waveney PCT.

In young people there is a strong correlation between STIs, risky sexual behaviour and drug and alcohol use. These links should not be ignored as many young people believe drugs have a positive effect on sex and the positive media coverage of ‘celebrity’ behaviour involving sex, drugs and alcohol acts as an encouragement to young people. The most vulnerable are the poorest in society which is clearly seen in Suffolk where the poorer communities in Ipswich and Lowestoft have higher teenage pregnancy rates when compared with the more affluent areas of Suffolk. An important future influence will also be the opening of University Campus Suffolk which could increase the number of 16-24 year olds by 20%.

We need to ensure that we take account of all the related factors when trying to improve the sexual health of young people in Suffolk. Prevention is a very important message: if a condom was used for every act of sex with a risk of an unplanned pregnancy or transfer of sexually transmitted infection there would be a massive and immediate impact on the rise in STIs and HIV; significantly fewer unplanned teenage and other pregnancies and a reduced number of terminations of pregnancy.

References

Independent Advisory Group on Sexual Health and HIV (2007), Sex, Drugs, Alcohol and Young People A review of the impact drugs and alcohol have on young people’s sexual behaviour. London, DH

5.5 Alcohol use in young people

Why is excessive alcohol consumption in young people a problem?

High levels of alcohol consumption in young people is associated with a range of high-risk behaviours such as unprotected sex which can lead to teenage pregnancy and sexually transmitted infections (Independent Advisory Group 2007). Although the relationship is not fully understood young people who are highly exploratory in one kind of...
behaviour tend to be highly exploratory in other areas. Young people who drink regularly are also more likely to offend and nearly half of 10-17 year olds who drink once a week or more admit to some sort of criminal or disorderly behaviour during or after drinking. Over one third of all offences relating to young people under 18 were committed by those who drank once a week or more. There are also strong links between high levels of youth alcohol consumption and truancy, school exclusion and illegal drug misuse (DH, 2007).

The number of hospital admissions related to alcohol consumption has been increasing among young people in England in recent years and admissions can relate to intoxication or accidents (DH, 2007). In addition alcohol is a contributory factor to accidents, some of which require admission to hospital.

It is not yet clear whether alcohol misuse in adolescence predicts drinking problems in adulthood (Foxcroft, 2002). Preventing alcohol related health and crime problems in younger people is important in itself but there is also concern about increasing longer term health effects of alcohol in younger people. In the last 30 years of the twentieth century the death rate from chronic liver disease amongst people aged 35-44 years increased eight fold in men and seven fold in women, and there was a four fold increase amongst 25-34 year olds (Donaldson, 2001).

How many young people drink too much?
A substantial proportion of older adolescents in the United Kingdom drink more that the recommended safe limits (Foxcroft, 2002). In 1990 young people under 18 drank an average of 5 units a week and this had increased to 10 units.
by 2000. National surveys have shown that although fewer young people aged 11-15 reported drinking alcohol over the past five years, the average amount drunk doubled over the 1990s in those who did drink. In the past 6 years alcohol consumption has remained stable in older adolescents, but has increased in those aged 11-13, although frequent alcohol use still increases with age and in 2006 41% of 15 year olds had drunk alcohol in the last week compared to 8% of 12 year olds (DH, 2007).

It has been suggested that young people see the use of alcohol as more acceptable than smoking cigarettes or cannabis and levels of drinking are linked with their parents and peers’ drinking (DH, 2007). Patterns of drinking change with age from predominantly drinking at home with parents or friends for 11-15 year olds, to drinking in pubs once over 16. Drinking by those aged 15 and under in unsupervised outdoor locations is closely linked with harm, and yet 4 out of 5 underage drinkers who attempt to buy alcohol from licensed premises are successful. In 2004 96% of 16 and 17 year old drinkers successfully purchased alcohol from shops and 98% from pubs. Overall there is a lack of information for young people about the effects of alcohol, and alcohol advertising is widely accessible to all who can read with some targeted at young people (Independent Advisory Group, 2007).

What is the extent of the problem in Suffolk?
There is limited data about alcohol drunk by young people in Suffolk but the data that is available suggests that the picture is not significantly different from the rest of the country. A survey of 788 students (16-25) at Suffolk College during 2002 showed that:

- 64.7% drank alcohol at least once a week and 8.2% of these drank every day
- 28% of females and 61% of males had drunk more that 20 units in a 24 hour period
- 11 females and 19 males had binged on 60 units at one session
- Focus groups showed that some young people set out to get drunk, drinking at home and then spending £50 in one night.

In 2003 a survey of 1,483 vulnerable young people aged 15-16 in Suffolk identified that 86% males and 87% females used alcohol either regularly or recreationally (NORCAS 2006).

**Figure 13:** Neighbourhood statistics/Synthetic estimate – binge drinking (% of binge drinking among persons over 16)

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Synthetic estimate (%) of binge drinking among persons over 16</th>
<th>Lower 95% confidence limit</th>
<th>Upper 95% confidence limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>15.1</td>
<td>17.3</td>
<td>13.0</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>15.5</td>
<td>18.8</td>
<td>12.3</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>15.7</td>
<td>18.0</td>
<td>13.5</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>15.0</td>
<td>17.1</td>
<td>12.9</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>14.2</td>
<td>16.2</td>
<td>12.3</td>
</tr>
<tr>
<td>Waveney</td>
<td>13.2</td>
<td>15.4</td>
<td>11.0</td>
</tr>
<tr>
<td>Ipswich</td>
<td>17.0</td>
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</tr>
<tr>
<td>England</td>
<td>18.2</td>
<td>18.8</td>
<td>17.6</td>
</tr>
<tr>
<td>East of England</td>
<td>16.7</td>
<td>18.4</td>
<td>15.0</td>
</tr>
</tbody>
</table>

Source: ONS Neighbourhood statistics
Binge drinking (drinking at least once a month and reporting feeling very drunk at least once a month in the last 12 months) is most common in those aged 18-24, but is a common form of misuse in those under the age of 18. In Suffolk estimates suggest that binge drinking is significantly below the national average in the Babergh, Mid Suffolk, Suffolk Coastal and Waveney areas, but is still a major concern.

The adverse health effects due to alcohol can be immediate such as accidental injury, or more long term where liver disease and stroke are significantly higher in those men who drink more than eight units a day and women regularly drinking more than six units a day. Information is not separately available for young people but almost 5,000 hospital admissions a year in Suffolk are due to alcohol related conditions and 1,000 deaths in Suffolk each year are attributed to alcohol. Worldwide, 5% of all deaths of young people between ages 15 and 29 are attributable to alcohol use (Foxcroft, 2002).

What are we doing in Suffolk?
The current Local Area Agreement has three alcohol related targets, to:

- Increase drug and alcohol education and awareness events delivered to local communities by 15%
- Reduce the number of violent crimes in a public places related to alcohol misuse by 10%
- Reduce the proportion of domestic violence incidents reported to the Police where alcohol was a factor by 10%.

There are various related initiatives, many sponsored by Crime and Disorder Reduction Partnerships, which aim to highlight the problems associated with excessive drinking or provide support to those who drink.

These include:
- Night Safe
- Ipswich Alcohol Harm Reduction Project
- Under 18 drinkers’ project – Ipswich
- Young people’s education through NORCAS
- Domestic Violence Alcohol Project
- PSHE harm reduction project in schools.

In November 2006 partners in Suffolk agreed a County Alcohol Strategy and the Drug and Alcohol Action Team has tasked a multi-agency group to monitor its implementation. The strategy has specific objectives for young people. Future work in this area will focus on:

- Ensuring that effective alcohol education is embedded within drug education PSHE programmes in all schools in Suffolk which achieve healthy schools status
- Ensuring that treatment pathways meet the needs of young people
- Engaging with parents and carers to promote safe drinking
- Engaging young people in diversionary activities so as to develop healthy and safe lifestyles
- Expanding work with licensees to ensure they are protecting young people from harm and are complying with the Restricted Sale of Alcohol policy.
Health improvement initiatives for children and young people

References


Alcohol concern: Young people’s drinking fact sheet


6
Update on health and social care information in Suffolk
Missing: information

Although this report provides a considerable amount of data and information about the health of the children and young people of Suffolk, there is a much that is not known, and a great deal of information that is still not accessible to us. For example, we know little about the important contributions made by the education sector, such as the content of PSHE in schools. Although the routine, annual collection of data about children’s weight and height has now begun, we still do not have any reliable information about the exercise children take or about their diets; information which we need if we are to know how and where to put effective safety measures in place, and where minor injury services should be provided and by whom.

Who knows anything about...?

Some data such as facts about individuals’ lifestyles, are simply not routinely collected at present. However, there is data which is routinely collected by different agencies, which if brought together, could give us valuable information and help us with interventions to improve health and in planning services.

We have been hindered in the past by not knowing what data other organisations were collecting, or by rules and legislation that prevented us from sharing information with one another, or by the fact that organisations collect information in different formats that couldn’t be put together. Now however, things are changing. Information technology makes it possible to manipulate large and complicated datasets in ways which would not otherwise be possible. We have a better understanding of personal confidentiality and information security, and more robust technological solutions for protecting electronic data. Nationally, the need for all government agencies and their partners in the voluntary and independent sectors to work together is better recognised and understood.

In Suffolk, we are currently working on joint projects between services and organisations that will give us a better information base and understanding for providing services in the future. The Children’s Trust Partnership Board published the first statutory Children and Young People’s Plan based on a joint needs assessment in 2006, and completed a joint review of progress made in the first year. A Joint Strategic Needs Assessment to support commissioning health and social care services in the county is also currently underway. These projects have enabled us to bring our information resources together across agencies in the county, and are helping us to plan how to work more effectively together in the future.
**Reward offered**

There is still a great deal for us to do in understanding how our different organisations work, what can be shared and what is unique to each organisation, how to make the best use of technology and the scarce information skills available to us, but the potential rewards for Suffolk are great. We expect that as time goes on, we will have information that is more reliable, more comprehensive and much richer, for understanding our communities’ needs and providing services to meet those needs.

**Acknowledgements**

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Please contact the address below if you would like additional copies of this report.

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